WOMEN IN ALASKA CONSTRUCTING THE RECOVERED SELF: A NARRATIVE APPROACH TO UNDERSTANDING LONG-TERM RECOVERY FROM ALCOHOL DEPENDENCE AND/OR ABUSE

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By

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ABSTRACT

Autobiographical narratives are explored in a qualitative approach regarding women in Alaska who have been successful in long-term recovery from alcohol dependence and/or abuse. The literature review includes an integrative approach to theoretical perspectives from the disciplines of Human Communication, Anthropology, and Psychology. The epistemological orientation of Constructionism grounds this study, as well as provides a framework for theoretical understandings from the narrative co-construction of self-identity, gender studies, health belief and health behavior change models, anthropological views on alcohol and culture including Native American and Alaska Native approaches, and various psychological and transpersonal strategies for overcoming alcohol addiction.

Today, a diverse resource of recovery paradigms and tools are available to women who have problems with alcohol. As a result, this study explores the applicability of various methods of recovery as they occur in the real lives of women in Alaska. Two emergent themes of recovery derived from nine narrative interviews are discussed in regard to identity reconstruction: (1) *Survivorship* and (2) the *Transcendent Self.* The emergent themes represent the reconstructed constitutive interpretations of a woman's self-identity as *the recovered self.* The process of recovery from alcohol dependence and/or abuse constitutes a uniquely personal and culturally specific journey for women. A recovered lifestyle is a completely different way of being for the woman who had previously been immersed in a culture of alcohol addiction—she now must construct a healthy self. A woman's process of recovery from alcohol addiction cannot be separated

from the world of social/cultural/gender interactions in the construction of a healthier lifestyle. Whether a recovering person's social interactions are with professionals or are everyday interpersonal exchanges with intimates and others, they form the context within which the discursive evolution of identity is embedded. The narrative stories of the lived world of women in Alaska who are maintaining long-term recovery from alcohol problems provide an understanding of cultural, ethnic, and gender influences, various treatment and recovery paradigms, relational tensions, and the process of identity construction in the maintenance of ongoing recovery.

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INTRODUCTION

According to the National Institute on Alcohol Abuse and Alcoholism (NIAAA), the risk of relapse is greater than 50 percent in women recovering from alcohol addiction. In addition, recent U. S. statistics regarding the number of women dependent on or abusing alcohol indicate there are nearly five million women who suffer from the effects of alcohol problems. The State of Alaska may be one of the least populated states in the U. S., yet according to the Division of Alcohol and Drug Abuse (DADA) for the State of Alaska alcohol dependence and/or abuse in Alaska tends to be at rates higher than national norms. Join Together, an ongoing ten-year project of the Boston University School of Public Health, has joined forces with Federal Agency co-sponsors, national organization co-sponsors, and private philanthropic co-sponsors to create the Demand Treatment project. Research from this project claims that "most people with drug or alcohol problems don't get the help they need . . . if more people got brief interventions and treatment, they would lead healthier and more productive lives" (Join Together, 2001). Additionally, the Healthy People 2010 campaign sponsored by the National Institute of Health (NIH) has set parameters and goals for the U.S. in regard to the reduction of alcohol dependence and/or abuse in targeted populations, one of which is maternal alcohol consumption (Healthy People 2010, 2000). The State of Alaska has created its own campaign in response to the national health campaign by instituting the Healthy Alaskans 2010 program to increase community health education and to increase compliance toward positive health behavior change in all Alaskan people in regard to major health concerns such as heart disease, cancer, stroke, diabetes, alcohol and drug

addiction, maternal drinking and fetal alcohol syndrome, cigarette smoking, obesity, and at-risk behaviors (Healthy Alaskans 2010, 2001).

At the core of recovery concerns from alcohol dependence and/or abuse is the current belief system of the person addicted to alcohol in regard to obtaining effective treatment. Many people will not get treatment because "they don't think that treatment or anything can help . . . they don't know what treatment is, [and] nobody has encouraged them to get help" (Join Together, 2001). Various programs of treatment and recovery from alcohol addiction espouse psychoeducational (PE) and experiential treatment models as being essential for success in recovery. However, many people choose to follow no prescribed course of action to change their negative health behaviors. Instead, they rough it out by going *cold turkey* in regard to making changes. Consequently, people desiring long-term recovery from alcohol addiction must all eventually follow a self-motivated program of recovery and maintenance after the throes of the initial treatment and recovery phase fade away, regardless if the recovery was originally a legal mandate, an intervention and treatment focused, or personally motivated and executed.

The State of Alaska's Governor's Advisory Board on Alcoholism and Drug Abuse (ABADA) in 2001 stipulated that the cost of alcohol abuse in the state was $453 million a year. In contrast, the cost of drug abuse was close to $161 million per year, which makes the total cost of substance abuse to the State of Alaska an overwhelming $614 million (ABADA, 2001). These figures are rather unsettling considering the state has estimated the lifetime expenditure for *one* person with fetal alcohol syndrome (FAS), fetal alcohol effects (FAE), or an alcohol-related birth defect (ARBD) is approximately $1.4 to $3

million (DHSS report, 2000, p. 12). FAS/FAE/ARBDs are completely preventable, which should direct part of the state's focus regarding alcohol abuse toward women who are alcohol dependent.

How are women living in Alaska situated socially and culturally in the development of alcohol problems? And how does that standpoint affect their health behavioral choices? One aim of this study is to explore issues such as gender, culture, location, relationships, family, and personal and psychological constitutive orientations related to women in Alaska with alcohol problems. Another goal of this research is to develop an understanding of the discursive co-construction of self-identity and how it functions in a woman's process of recovery from alcohol dependence and/or abuse. As a consequence, this research study explores the reconstruction of self-identity within the lived world of women in Alaska who have successful long-term recovery from alcohol dependence and/or abuse. Concerns surrounding active addiction to alcohol, treatment, and recovery are fundamentally different for women with respect to pregnancy and the nursing mother as well as enculturated gender prescriptions and ethnic background.

In order to explore various issues related to women and long-term recovery, it is necessary to ask in-depth and appropriate questions regarding alcohol dependence and/or abuse such as: (a) how do women succeed with ongoing recovery from alcohol addiction?, (b) what life circumstances set the stage for a woman to choose recovery rather than opting to stay mired in the depths of alcohol addiction, denial, despair, and at-risk behavior?, and finally (c) how do women reconstruct their self-identity toward a

healthy sense of self in the ongoing daily process of recovery from alcohol dependence and/or abuse? Women who have been in continuous recovery have revelatory and meaningful stories to share about their process of recovering from alcohol addiction. They are the experts we can turn to for an understanding of women's journeys toward a healthy construction of self as a *recovered self.*

CHAPTER I

Review of Literature

The purpose of this study is to create an understanding of how women living in Alaska reconstruct their self-identity for long-term success in recovery from alcohol dependence and/or abuse. An exploration of various theoretical perspectives from human science research on alcohol treatment and recovery forms part of the framework for this study so that women's experience of ongoing recovery from problems with alcohol can be contextualized within an academic interpretation and analytical discussion. An integrative approach to various theoretical perspectives from the disciplines of Human Communication, Anthropology, and Psychology provide the structure and foundation for this qualitative research study. Cultural and gender perspectives from anthropological and psychological viewpoints as well as from human science perspectives were blended in an exploration of interpreted understanding of women's identity construction in the recovery process. In addition, aspects of meaning-making in interpersonal communication based upon the Theory of the Social Construction of Reality (Berger & Luckmann, 1967) and the epistemology of Constructionism (Crotty, 1998; Gergen, 1994a, 1994c, 1999; Jacoby & Ochs, 1995), as well as the centrality of the discursive self in identity construction (Gergen, 1991, 1994b; Gergen & Gergen, 1993; Harré, 1989; Harré & Gillett, 1994) are combined with cultural studies of recovery from alcohol dependence and/or abuse.

Finally, explorations of current trends in alcohol and addiction research are utilized in terms of long-term success in recovery from alcohol dependence and/or abuse.

This discussion embeds differing models of treatment and recovery for discussion of maintenance of health behavior change such as perspectives from health belief models, the Alcoholics Anonymous (A.A.) 12-step program model, the medical model, family therapy, therapeutic communities, various forms of psychological counseling (e.g., cognitive-affective, and behavioral models), relapse prevention (RP), American Indian and Alaska Native ways of healing, and transpersonal psychological perspectives in the process of recovery from problems with alcohol. Additionally, a communication model for the social construction of self-identity (Richey, 2003) has been proposed and delineated for inclusion as an in-depth philosophical and analytical way to understand identity construction and reconstruction in regard to recovery through discursive means.

A Gendered Perspective:

An Embedded Sociocultural Framework for Identity Construction

A discussion of contrasting models can be understood from the conceptual framework that each model of treatment and recovery can be considered distinct cultures in regard to how people integrate new perspectives about their recovery through social learning and adaptation to change. Embedded within a cultural concept of recovery are issues relating to a person's own cultural/ethnic/gender background. Minority and/or marginalized people in our society can be set up for failure in recovery when attempting to maneuver within the pervasive hierarchical structures inherent in our white, Anglo-Saxon, patriarchal society (Madsen, 1974, p. 157). The notion of marginality often includes gender standpoint and positionality as an ongoing tension within everyday social interactions. For example, differences in gendered ways of relating can become factors

in treatment and recovery in how women tend to interact with men and other women. Gendered ways of being include concepts such as women's style of communicating, which centralizes the value of personal relationships as in the notion of "rapport-talk" versus men's style of communication, which focuses on content and task-orientation characterized as "report-talk" (Tannen, 1996, p. 69). The concept of power differentials between men and women in U.S. society is a culturally embedded given and is brought forward as part of an academic discussion regarding the relevance of societal gender prescriptions (Ardener, 1992; Gilligan, 1982; Kramerae, 1981; Lorber, 1997; Reinharz, 1992; Schaef, 1981; Tong, 1993, Wood, 1993a, 1993b, 1996b, 2001) in relation to tensions in recovery strategies.

Women, the Second Sex in Whose Voice?

More than 50 years have past since Simone de Beauvoir's seminal, critical work, *The Second Sex*, was unleashed upon the collective minds of American women (Beauvoir, 1964). In the 1960s and 1970s, the second wave of the U.S. feminist movement gathered tremendous momentum. Women's collective identities were evolving away from a silent acceptance of secondary social status within a patriarchal culture. Wood (2001) describes the women of this era in the U.S. women's movement as "claiming a voice in defining who they were and what rights, roles, and opportunities they should have" (p. 69). As a society, we have traversed through many shifts in feminist awareness and differing approaches regarding a so-called *correct* political feminist stance. Tensions between radical, liberal, separatist, and power feminism have become the feminist discourse today. A recent third wave of feminism is emerging, but

has not fully defined itself (p. 84). However, the voice of this new feminist phase does seem to have the notion of inclusion at its core.

An exploration of feminist theory can offer a better understanding of women in regard to alcohol dependence and alcohol abuse. A theoretical overview of the social construction of reality related to health behavior and illness as well as an exploration of ideas from the roots of the second wave of feminism in regard to gender differences can further unpack these ideas. The notion of gender as a socially constructed process of identity creation allows for a biopsychosocial, holistic approach to the study of women and alcohol abuse in general within North American culture as well as specifically in Alaska.

The Construction of Gender—Symbolic Systems & the Socialization of Gender

Biological differences between men and women may seem too obvious as a starting place to build an argument for gender variance. However, these evidential sexual differences often form the basis for socially perceived and interpreted discriminatory practices. In the socialization process of men and women in U.S. culture, women have been historically and systematically subjugated to a lesser social status. Although the gap between socialized differences is lessening in some regions of the U.S., there remains a long, arduous consciousness-raising journey ahead toward a gender equality consensus. Subsequently, an understanding of gender construction should logically begin by exploring the primary relationship most of us experience as human beings—the maternal relationship.

Chodorow's psychoanalytic study of gender identity development posits that women's gender construction is embedded in the mother-daughter relationship. According to Chodorow, arguments regarding the differences between men and women based on biology and/or "patterns of deliberate socialization" (Chodorow, 1974, p. 43) do not provide a complete understanding of the construction of gender identity in women. The norm in most cultures is that women take on the role of nurturer for both female and male children. An underlying notion in regard to women's role as *mother* suggests that there is a sociocultural difference in the way girls and boys are raised. Chodorow's central theme regarding gender identity construction in women focuses on the idea that women, who enact the mothering role, are the perpetuators of the "universal secondary status" of women (p. 45). In this sense, women not only learn concepts of femininity from their mothers, they also internalize the social roles and norms for being female in a given culture as interpreted by their own mothers.

The mother-child relationship is the crux of the gendered construction of identity. Chodorow (1997) emphatically insists that:

> gender difference is not absolute, abstract, or irreducible; it does not involve an essence of gender. Gender differences, and the experience of difference, like differences among women, are socially and psychologically created and situated. . . . [this] suggests a relational notion of difference. Difference and gender difference do not exist as things in themselves; they are created relationally, that is, in relationship. We cannot understand difference apart from this relational construction. (p. 9)

In regard to psychological development, children cannot differentiate between "self and world" (p. 11). The child knows no boundaries in the infant state, but must painfully learn that boundaries do exist between the mother and the self. This distinction between *self* and *other* is the first developmental stage of insipient gender construction. Chodorow's ideas diverge from traditional psychoanalytical thought, because she views this process of differentiation as a *relational* process. To understand the child's awareness of the self and other, she suggests that there is something fundamental within the mother-child relationship that enables the development of this distinction. The rhetoric of Chodorow's viewpoint on gender construction suggests that differentiation is not formulated upon "distinctness and separateness . . . but [instead upon] a particular way of being connected to others" (p. 14). Therefore, most children of both sexes construct and internalize their gender attitudes and beliefs within a gendered primary relationship with a mother.

Other feminist theorists inform gender construction through other relational processes and social structures within U.S culture (Ardener, 1973/1989; Ardener, 1992; Chow, Wilkinson, & Zinn, 1996; Collier & Rosaldo, 1981; Gilligan, 1982/1993, 1997; Hartsock, 1983, 1997a, 1997b; Kramarae, 1981, 1996; MacCormack & Strathern, 1980; Orbe, 1998a, 1998b; Ortner & Whitehead, 1981; Rosaldo & Lamphere, 1974; Schaef, 1981; Stewart, 1997; Tannen, 1990, 1996; Tong, 1993; Wood, 1993, 1996, 2001). Rosaldo explores the asymmetry of cultural evaluations of sex roles (Rosaldo, 1974, p. 18). Power asymmetry can be generalized cross-culturally as "cultural systems, [which] give authority and value to the roles and activities of men" (p. 19). This perspective

implies that women's activities tend to be trivialized as less important in male dominant cultures as well as underscoring a potential experience of struggle to women's aspirations and self-growth. Rosaldo (1974) reviewed ethnographic literature from diverse cultures regarding the notion that women have been "traditionally ignored" (p. 21). She argued that a universal subordination of women relates to the gendered "differentiation of domestic and public spheres of activity" (p. 23). Women have traditionally focused on childbirth and child rearing. In contrast, men have had more freedom to develop activities outside the domestic environment. A culturally constructed value difference attached to public and domestic spheres of activity is fundamental to an interpretation of inequity between the sexes. In contrast, according to Rosaldo and Lamphere (1974), more egalitarian societies have less gender differentiation between the public and domestic spheres.

Ortner and Whitehead (1981) make a clear distinction between conceptualizing the differences between men and women as cultural constructions rather than as "natural objects" (p. 1). They posit that gender and sexuality are a "matter of symbolic analysis and interpretation" (p. 2) in context to specific cultural experiences. Ortner and Whitehead suggest that "spheres of action" (p. 8) for men and women define how men and women are perceived culturally. Terms used for men such as "warrior, hunter, statesman, and elder" (p. 8) relate to what they do beyond their relationships with women. However, women's terms are often derived from their relationship to men such as "wife, mother, sister" (p. 8). A careful reflection on this distinction between *doing* and *relating* can lead to an in-depth understanding of a gendered construction of women

organized and defined primarily by men. Gilligan (1982/1987, 1992), Tannen (1990, 1996), Tong (1993), and Wood (1993a, 1996, 2001) reiterate this viewpoint by suggesting that the traditional nurturing and caring roles performed by women have been developed through relational means.

Other origins of this viewpoint developed in the middle of the 19th century, when anthropologists initiated a dialogue regarding a so-called "natural explanation of gender differences" (MacCormack, 1980, p. 7). Models that illustrated the transformation of nature into culture, wild into tame, female into male and so on were created to metaphorically describe human sociocultural evolution. Similar models could be created for different cultures in terms of gender construction. MacCormack, as well, suggests that we derive gender distinctions from "our perceptions of what men and women do" (p. 13). A model for a patriarchal society such as U.S. culture in regard to constructed gender development has traditionally appeared as: domestic sphere—women/children/spouse versus public sphere—men/work/family. The gender distinction in the model locates women in the center of home and its various extended family relationships. In contrast, men are associated with work outside the home in order to sustain self and the family as a unit. Although, this socially constructed hierarchy has been in flux for the past 80 years or so, models of sociocultural structure can be helpful in describing what is observed and what has seemingly become institutionalized within a given culture. Social practices are continually changing over time; thus, it is periodically necessary to adjust our viewpoints. A present day, 21st century model of gender construction in U.S. society is slowly evolving closer to an egalitarian orientation, which

at some point in time may be fully experienced as: domestic sphere—children/spouse/women and/or men versus public sphere—work/family/women and/or men.

Although, we cannot deny the social ramifications of women's cultural heritage and legacy in regard to gender constructions; we also must be open to new constructions as they occur in lived experience. Otherwise we, as social researchers, risk trailing behind current social trends in our academic feminist discourse as well as continuing to rehash older versions of shifting and evolving social conditions such as gender-constructed bias. A popular myth regarding social change stipulates that societies take at least a century to fully shift deeply ingrained collective thoughts and conditions. If we place some credence to this myth, then, the feminist discourse of the second wave has only been acting on the collective minds of U.S. culture for approximately 30 to 40 years. We have a long way to go as a society before women and other marginalized groups achieve equal recognition and inclusion within political and public structures.

Muted Groups Theory

General patterns of gender socialization in the U.S. culture, including Alaska, can be understood by delineating power differentials in language and social expectations of women in various ethnic and subcultural backgrounds. For instance, language is constructed by the people who are in a position of power within a particular culture. In Western society, women and other marginalized groups have historically been:

> not as free or able as men are to say what they wish, when and where they wish . . . Women's perceptions differ from those of men because women's

> subordination means they experience life differently . . . words and norms for speaking are not generated from or fitted to women's experiences. Women are thus muted. Their talk is often not considered of much value by men-who are or appear to be, deaf, and blind to much of women's experiences. Words constantly ignored may eventually come to be unspoken and perhaps even unthought. (Kramerae, 1981, p. 1)

Kramarae suggests a two-fold conceptualization of the structures inherent in the creation of muted groups within cultures: first, cultural beliefs and rules that formulate a particular worldview (template structures) and secondly, the "articulation of their world view" (structure of realization) (p. 1). Additionally, Kramarae formulated three tenets in regard to women as a muted group which describe her perspective:

> (a) women perceive the world differently – rooted in the division of labor, (b) because of men's political dominance, men's system of perception is dominant, impeding the free expression of the women's alternative models of the world; [and lastly], (c) in order to participate in society women must transform their own models in terms of the received male system of expression. (p. 3)

Other feminist muted groups theorists, such as Ardener and Orbe, "also hold that a language reflects a world view" (Kramarae, 1981, p. 3). The framework of the muted groups theory can be applied equally to any groups that are in asymmetrical power relationships such as women in general, gay men and lesbians, Alaska Natives, or other racially, ethnically, or socially marginalized groups. A state of inequality existing

amongst groups within a particular culture "blocks the power of actualization of the other" (Ardener, 1973/1989).

Co-Cultural Communication Theory, Standpoint Theory, & Positionality

Orbe's (1998) co-cultural communication theory is informed by understandings developed from feminist perspectives regarding dominant and marginalized cultural members co-existing and interacting in common cultural settings. Muted groups theory, standpoint theory (Hartsock, 1983, 1997a, 1997b; Wood, 1996c), and views on positionality (Davies, 1992; Davies & Harré, 1990) add conceptual support to an understanding of co-cultural communication theoretical concepts. Whereas muted groups theory addresses the voice of co-cultural members who are marginalized, standpoint theory recognizes that the context of individuals' social location fuels their unique version of reality. The notion of positionality or of "positioning" (Davies, 1992; Davies & Harré, 1990) in a communication event refers to a speaker's position within interaction (e.g., privileged or non-privileged). In addition, standpoint theory and ideas regarding a speaker's position centralize how other cultural members interpret cultural others' interactions. Power asymmetry is at the root of a particular group's *mutedness*, standpoint, and *positioning*. Language within cultural communication channels and structures are based on privileged members' constructions and contributions rather than made by those who are rendered invisible in the hierarchical mobility of privileged cultural members. The use of terms such as in-groups and out-groups, or cultural familiars and cultural strangers, cannot fully describe the process of the co-constructed, intercultural, pluralistic reality in which we live in U.S. society. The notion of people in

the U.S. existing in multiple worlds or in multicultural social environments makes more sense in regard to everyday interactions and communicative negotiations. Orbe (1998) refers to this notion as "co-cultural group communication" (p. 30). In addition, the use of the prefix, "co," implies an underlying sense of equality, togetherness, or mutuality in relating with cultural others rather than the use of descriptive language rooted in a rhetorical framework of power asymmetry. Terms such as minority, subcultural, subdominant, marginalized, disenfranchised, or even "muted group" (Kramarae, 1981; Orbe, 1998), tend to perpetuate ethnocentric bias in intercultural communication.

Standpoint theory has its roots in Marxism and has been extended into a feminist postmodernism. Welton (1997) suggests that feminist standpoint theory relates to situated knowledge or how the "concept of experience is used in the construction of the feminist standpoint" (p. 8). For example, additional core concepts resulting from feminist standpoint theory such as "the view from somewhere, social location, positionality, standpoint, embodiment, contextuality, intersectionality, local knowledges, and global capital are notions that line many a feminist toolbox for good reasons" (Barad, 2001, pp. 75-76). Hartsock refers to standpoint theory as "concrete multiplicity," which suggests, "knowledge production is a communal activity" (Welton, 1997, p. 19). She further explicates standpoint concepts to be understood as how race and sex, as systems of domination, influence class (p. 9). Welton's (1997) discussion of Hartsock's standpoint theory suggests an "early formulation of the feminist standpoint is also concerned with retheorizing power from a feminist perspective" (p.9). Additionally, Hartsock (1983) in her own words regards standpoint theory as praxis since "one can

only know and appropriate the world (change and be changed by it) through practical activity" (p. 95). Another important consideration regarding feminist standpoint is that it "would raise, for the first time in human history, the possibility of a fully human community, a community structured by a variety of connections rather than separation and opposition" (Hartsock, 1983, p. 247). Hartsock has responded to Welton's critique of her original work on standpoint theory by clarifying her ideas:

> Welton also makes the point that I fail to specify how experience becomes mediated and transformed into a standpoint. I say no more than that knowledge grows in complex and contradictory way from experience. I can now add that I see this transformation as one that involves theoretical (but sometimes physical) migrations, learning to speak in a voice the dominant culture both suppresses and claims cannot exist and finally coming to see and name the ideology and social relations of the dominant culture as insane. (Hartsock, 1997, p. 95)

A final evaluation of ideas from Hartsock's standpoint theory indicates we should "question whether present conceptions of power might be understood as masculine . . . we might come to understand power a little better by an approach that includes the previously neglected resource of women's lived experience" (Welton, 1997, p. 11).

As a necessary augmentation to this discussion of situated knowledge, lived experience/meaning, and privileged versus non-privileged societal perspectives is the notion of the social position of interactants. Davies (1992) explicates this idea as "the myth of the positionless" (p. 55) speaker. The focus of her work is on women as speakers, which suggests that the dominant voice for discourse in U.S. society in general

as well as in academic representations of the study of human beings is male. She reminds her audience that we all have a position in our interactions with others, especially in our scientific discourse:

> men . . . have believed that they speak as *man*, a category inclusive of men and women. But their position has been a privileged one and often was totally incorrect when it presumed to speak for or of anyone other than white middle-class males. Women, in contrast, have always had their position as female speakers *marked*. . . . (Davies, 1992, pp. 54-55)

In this respect, women as speakers in U.S society tend to be very aware and sensitive to their social position as being female, which involves the complete array of cultural, subcultural, and regional biases. If we were to ignore or decentralize a gender perspective in regard to social interaction, we would be missing underlying contributory aspects of specific behaviors, especially related to cross-gender communication and relationship.

The combination of muted groups theory and standpoint theory into a unified co-cultural communication theory supports a more holistic approach to the study of gendered constructions of identity. Women in the diverse culture of the U.S. have traditionally been muted in such specific ways that their co-cultural standpoints uniquely affect their own communicative cultural interactions as well as affect how they are perceived and interpreted by co-cultural others. The layering of these co-cultural contextual standpoints and positionings in women from diverse backgrounds helps to inform some of the peculiar and apparently self-destructive health behaviors enacted by women in our

culture such as those related to alcohol dependency and alcohol abuse. Alcohol dependence and/or abuse can be understood from a more in-depth perspective if its construction is considered as a gendered co-cultural process within the framework of particular sociocultural locations. This notion is central to an understanding of the lived experience of women living in Alaska and alcohol problems.

Gendered Perspectives in Illness & Health—A Paradox?

According to Lorber (1994), human behavior is the culmination of learned cultural practices, which are "imbued with moral and symbolic meaning" (pp. 123-124). She states that gender is only a paradox if it is not understood contextually as "rooted in conflict over scarce resources and in social relationships of power" (p. 6). Gender conceptualized this way is a "human invention, like language, kinship, religion, and technology . . . gender organizes human social life in culturally patterned ways" (p. 6). These culturally gendered patterns can be recognized as well within concepts of illness and health behavior. Lorber (1997) discusses illness and health within context of a "transformation of the body through gendered social practices" (p. 3). The outcome of these sociocultural practices transforms "physical bodies into social bodies" (p. 3). The notion of the combination of physicality and sociality in regard to the human body undergirds a gendered construction of how one's body and related culturally imbued behaviors can be understood through an interpretation of lived experience, especially in regard to how women construct their health behaviors.

Social & Gender Construction of Health Behavior

According to Lorber (1997), "social context" (p. 6) is a central aspect of illness and health behavior. People in recovery from illness cannot separate their physical and psychological reactions from the whole context of healthcare delivery and their social connections. Current trends in both health communication and health psychology approach illness and health behavior from a biopsychosocial perspective (Brannon and Feist, 2000, p.11; Healthy People 2010, 2000; Healthy Alaskans 2010, 2001). This integrated healthcare and recovery viewpoint locates the social component of health behavior as a co-constructed process. One aspect of illness and health behavior relates to the biopsychosocial context of women in recovery from alcohol dependence and alcohol abuse.

This discussion of illness and health behavior centralizes social practices and processes in conceptualizing a gendered construction of addiction and recovery. Some concerns related to the theory of social construction of reality apply well to an understanding of women in recovery. Gergen (1994) posits that relationships with others constitute people's formulations of reality:

> The terms and forms by which we achieve understanding of the world and ourselves are social artifacts, products of *historically and culturally situated interchanges* [italics added] among people. For constructionists, descriptions and explanations are neither driven by the world as it is, nor are they the inexorable outcome of genetic or structural propensities within the individual. Rather, they are the result of human coordination and action. . . . to achieve intelligibility is to

> participate in a reiterative pattern of relationship, or if sufficiently extended, a tradition. It is only by virtue of sustaining some form of past relationship that we can make sense at all. (p. 49)

Constructionists view human reality as a dynamic process of meaning-making contingent upon human interaction and interpretive practices within cultural frameworks. In this sense, health behavior and recovery processes are constructed in intrinsically interwoven, complex social systems. Gergen (2001) has extended concepts of social construction into an in-depth analysis of the therapeutic process. He suggests that therapy is a "process of relational construction" (p. 97).

Another important consideration in regard to the social construction of alcohol addiction and health behavior is that the medical diagnostic process of illness is embedded in socially created organizations and practices. Brown (1995) situates social construction as the central process by which "health, illness, and healing" are influenced by "the effects of class, race, gender, language, technology, culture, . . . institutional and professional structures and norms" (p. 34). For instance, a predominant view of alcohol dependence and/or abuse as a disease stems from conceptualizations derived from the medical model. The disease model (Jellinek, 1960) of alcoholism [sic] has been a pervasive influence on the minds of the U.S. public. The disease model is an example of how social institutions foster and perpetuate social understandings of particular phenomena regardless of their questionable or limited applicability. Though other models of alcohol dependence and/or abuse have been introduced subsequently such as the "alcohol dependence syndrome" (Edwards, 1977), the disease model continues to

frame a way of understanding alcohol addiction for many people, especially those individuals involved in Alcoholics Anonymous (AA).

According to Brown (1995), sociologists view the health status of an individual within the context of "social causation" (p. 38). Three categories of causation discussed in Brown's *Social Construction of Diagnosis and Illness* are (a) "underlying social causes; (b) proximate social causes; and (c) mediating social causes" (p. 38). A view of diagnosis and illness as constructed in and through social means allows us to systematically understand particular individuals such as women and their embodied health behaviors within the full contexture of human health behavior as being truly gendered "social bodies" (Lorber, 1997, p. 3).

Alcohol & the Construction of Relationships

A final general area related to gender construction in women as it relates to alcohol dependence and/or abuse is the notion of family and relational dysfunction or co-dependency. Co-dependence is a construct that has developed over the past several decades in the fields that treat people with alcoholic and addictive behaviors. Women tend to enact co-dependent roles in personal and family relationships more than men do because of the ways in which women have been socialized within a predominately patriarchal system.

Schaef (1986) refers to co-dependence as a "disease process . . ., [which is an] addictive process . . . unhealthy and abnormal . . . whose assumptions, beliefs, behaviors and lack of spirituality lead to a process of nonliving that is progressively death-oriented" (p. 21). In contrast to the progressive death of alcohol dependence and/or abuse or drug

addiction, Schaef defines the construct of sobriety as "a person's living process and/or spirituality" (p. 24).

Beattie (1989) refers to this process as the "quest for normal" because children in alcoholic family systems have been "deprived of good feelings . . . believ[ing] life wasn't worth living" (p. 114). The chemical dependency field considers a person as having addictive behaviors when the "substance or process outside the person . . . becomes more important than sobriety" (Schaef, 1986, p. 24). This notion locates a person's way of relating to intimate others as part of the addictive process. A central concept regarding addiction as a process rather than just as a physical dependence on a particular substance is the idea that people will often switch their focus to other substances "such as nicotine, caffeine, or sugar" and even to relational others when the more destructive chemical is removed (p. 24). Treatment then, according to Schaef (1981, 1986, 1987), for substance abuse should take a holistic approach by treating the addictive behaviors in the person and should not be solely aimed at the removal of a particular substance.

Partners and family members of individuals with alcohol dependency and/or abuse suffer from a so-called addictive disease as well. This is the disease process of co-dependence. An "untreated, unrecovered, nonsober enabler" is doomed to repeat the same tragic addictive relational behaviors with the untreated or treated alcoholic as well as with any other future partner (p. 24). Schaef asserts that the behavioral patterns of co-dependency are part of the addictive process for both the alcoholic (substance abuser) and partner as well as family members.

Brown & Lewis (1999) refer to the partner of an alcoholic as the "coalcoholic" (p. 207). This term defines the nature of the relational interaction between the alcoholic and his or her relational partner or other family members. When the alcoholic system in the relationship and/or family is about to collapse, the coalcoholic or co-dependent partner (usually a woman) must hit some kind of emotional bottom as well. This is the period when the "partner intensifies his or her attempts to control the alcoholic . . . to rescue or just hold together the alcoholic family system that is heading toward collapse" (p. 207). The coalcoholic can act as a "catalyst for the alcoholic to hit bottom too" (p. 207). When children are involved in the alcoholic family relationship, they are especially traumatized by the move from uncontrolled drinking to abstinence. The problematical alcoholic behavior and the attempts toward abstinence are extremely traumatic and stressful for children. Family members must "face the void of new abstinence without a healthy family structure to hold them" (p. 211). Children can respond to the struggle for abstinence phase of the alcoholic in a negative way since "everything is now unknown and unpredictable" (p. 211). Their experience with the alcoholic family system seems more real albeit dysfunctional than the new abstinence territory.

A central concept in the addictive process relates to issues of co-dependency, which surface with intensity after the various addictive substances are removed from the individual's life. Schaef discusses the similarities in the ideology of co-dependence and the chemically dependent family system with that of the so-called dysfunctional family system understood in family therapy literature. She equates terms used in both paradigms such as "the identified patient" in family therapy with the "addict" in the chemical

dependency (CD) viewpoint (Schaef, 1986, p. 38). Both paradigms are essentially looking at the same process (the addictive process), but calling it by different names. Since Schaef believes that co-dependence, dysfunction in the family, and issues of chemical dependence are all a similar process, she has offered a list of characteristics common to people embroiled in the disease process of co-dependence:

> (a) dishonesty . . . , (b) not dealing with feelings in a healthy way . . . , (c) control; confusion; thinking disorders . . . , (d) perfectionism, external referenting—being other-directed . . . , (e) dependency issues, fear, rigidity; judgmentalism; depression; inferiority/grandiosity; self-centeredness; loss of personal morality. . ., (f) stasis . . . , and (g) negativism. (pp. 42-43)

High risk groups for the development of the so-called disease of co-dependence would include "spouses of addicts [especially, women]; recovering addicts; adult children of alcoholics; young children with workaholic parents, grandparents, or siblings; and professional who work with addictive persons . . . families with a secret or trauma, families that do not foster autonomy, and families that reward learned helplessness" (p. 43).

Relationship addiction and a sense of self with no boundaries are hallmarks of the dysfunctional behaviors of the co-dependent person, both men and women (Beattie, 1989; Irvine, 1999; Schaef, 1986, 1987). The co-dependent's experience with "family, school, and church—actively train [them] not to form boundaries" (Schaef, 1986, p. 46). Schaef defines this concept as "cultural co-dependence training" (p. 46). In regard to the insidiousness of co-dependence, members of the alcoholic family system tend to take on

the problems of the alcoholic. They try to fix problems, which are not necessarily of their own creation. Treatment for the complexity of these problems can be a daunting task for both the women and men in recovery, their family members, and the therapist.

Co-dependent people seem to require being needed thereby becoming focused on a caregiving role in regard to the alcohol-addicted or chemically dependent partner. This tendency makes co-dependents "indispensable" since they often think that no one "would want to have them around for their intrinsic worth" (p. 53). Traditionally, the nurturing or caregiving role is a gender-constructed social role (Chodorow, 1974, 1997; Gilligan, 1982/1993, 1997; Tannen, 1990, 1996; Tong, 1993; Wood, 1993a, 1993b, 1996b, 2001). Alcohol dependent women who take on the co-dependent role in the family or in a relationship have a double dilemma to face in regard to recovery—the release of an addictive substance and the release of control in personal relationships.

Alaskan Women & the Construction of Alcohol Dependence and/or Abuse

So far in this discussion of social and gendered construction of health behavior, feminist and social constructionist theory has been generalized to U.S. culture. In order to apply these concepts to Alaskan women, there are a few pertinent areas related to the sociocultural, historical and contemporary gendered influences on women in Alaska, as well as certain ramifications of Alaska's physical environment on health behavior.

Alaska is populated by diverse groups of people including descendants from the indigenous Alaska Native groups, Russian colonizers, and American pioneers, as well as by immigrants from other countries worldwide and people relocating from the Lower 48 and Hawaii. Both European and Alaska Native patriarchal social systems have

influenced the socialization of women in Alaska. A previous discussion in this study of feminist theoretical viewpoints such as muted groups theory, standpoint theory, and positionality informs a gendered construction of women and health behavior in general. One could reasonably infer that gender construction in Alaskan women has been constitutively similar in regard to a patriarchal orientation as for U.S. women in general.

In addition, the social structure of most Alaska Native cultures is predominately patriarchal. However, there are a few unique situations peculiar to Alaska that may skew a biopsychosocial, gendered construction of alcohol dependence and/or abuse in Alaskan women. Four areas unique to Alaska related to alcohol abuse are central to a gendered construction of alcohol dependence in Alaskan women: (a) depression and seasonal affective disorder, (b) domestic violence, intimate partner abuse, and child abuse, (c) maternal drinking and fetal alcohol syndrome, and (d) dissolution of the Alaska Native cultures and the roles of Alaska Native women.

Seasonal Affective Disorder & Women

Not only do more people in Alaska suffer from seasonal affective disorder (SAD) than in the Lower 48, but more women than men in Alaska tend to report symptoms of SAD (Booker & Hellekson, 1992). Typical symptoms of SAD, in addition to depression, can include sleep disturbances, carbohydrate cravings, an increased desire for alcohol, weight gain, moodiness, irritability, and hostility (Booker & Hellekson, 1992; Brower, Aldrich, Robinson, Zucker, & Greden, 2001; McGrath & Yahia, 1993; Paschane, 1998). The long, dark nights and extreme temperatures in the Alaskan winter contribute to symptoms of depression and SAD as well as increase the potential of other factors related

to alcohol dependence and/or abuse such as isolation, victimization, dysfunctional relationships, intimate partner abuse, maternal alcohol consumption and fetal alcohol syndrome (FAS), child neglect and abuse, incest, accidents, AIDS/HIV, homelessness, violence, homicide, and suicide (Becker & Walton-Moss, 2001; Van der Walde, Urgenson, Weltz, & Hanna, 2002). Women suffering from depression often practice self-medication with alcohol and drugs to alleviate problematical symptoms. Unfortunately, the use of alcohol and drugs to medicate mental and emotional symptoms can become a vicious cycle of continued depression and substance abuse.

Treatment and recovery specialists refer to the combination of mental illness and substance abuse as dual diagnosis. According to Brady et al. (1996), dual diagnosed individuals will "often completely deny their substance abuse and mental illness . . . . others . . . may acknowledge difficulties with . . . [one] but not both, resulting in . . . one area being undermined by continuing problems in the other area" (pp. 573-574). Although, both men and women can suffer from depression and/or alcohol dependence and/or abuse, women in Alaska seem to be particularly vulnerable to the development of SAD. As a consequence, some women may be more susceptible to the development of alcohol dependence in the process of self-medication as a treatment for the effects of depression as well as to assuage connected social by-products of SAD and alcohol dependence and/or abuse —family and relational disruption.

Domestic Violence, Intimate Partner Abuse, & Child Abuse

Women are two to three times more likely to report intimate partner intimidation, but more than seven to 14 times more likely than men to report actual physical abuse by

an intimate partner (Tjaden & Thoennes, 2000). Other research on intimate partner abuse has estimated approximately 4 million American women are assaulted by an intimate partner each year (APA, 1996, p. 10). Therefore, a second area of concern related to women and alcohol in Alaska is the incidence of domestic violence in connection to alcohol abuse. In Alaska during 1996, one out of 26 Alaskan women sought assistance in regard to domestic violence (Chamberlain, 1996, p. 3). And, according to Chamberlain (1996), alcohol and other substance abuse are often linked to intimate partner, domestic, and child abuse (p. 21). For example, the incidence of a history of child abuse is extremely high in Alaska Native women who sought help for domestic violence; 75 percent of these women reported being sexually abused in childhood, Robin et al. study (as cited in Segal, 2001). Particular findings from alcohol research show that approximately 47 percent of women treated for substance abuse have been physically and sexually abused, Copeland and Hall's study (as cited in Segal, 2001). Finally, a comparison of Alaska non-Native women and Alaska Native women has shown that the incidence of violence linked to substance abuse increases dramatically, close to 65 percent, Stockholm & Helms' study (as cited in Segal, 2001). An Alaska study of victimized Alaska Native women and substance abuse has concluded that:

> sexual victimization has a specific connection to women's substance misuse problems. It is also evident that Alaska Native women demonstrate higher levels of victimization than their non-Native counterparts. Moreover, multiple-violence is present, and the current data indicate intergenerational violence (i.e., abuse of children) has occurred. (Segal, 2001)

The old adage, *violence breeds violence*, connected to alcohol and substance abuse appears to be a central social construct involved in the physical, emotional, and sexual abuse of many Alaskan women.

Maternal Alcohol Consumption & FAS

A third area related to a gendered construction of women in regard to alcohol dependency and alcohol abuse is maternal alcohol consumption, which is the cause of FAS/FAE and ARBDs in Alaska. The notion that FAS/FAE/ARBDs are twice as high in Alaska as in the Lower 48 and Hawaii highlights the development of strategies to improve health education. State sponsored research results from 1995-1998 in Alaska has estimated the prevalence rate for FAS in Alaska to be "1.0 to 1.4 births per 1,000" compared to the estimated national rate of 0.1 to 0.7 births per 1,000 (DHSS report, 2000, p. 3). Results from Alaska's 1991 FAS Surveillance Project indicate the prevalence rate of FAS in the Alaska Native population is more than four times higher (4.8 per 1,000 births) than the overall rate in Alaska (FAS Status Update, 2001, p. 18). These alarming surveillance project findings have caused the State of Alaska to aggressively seek solutions for FAS/FAE and ARBDs statewide. According to research on FAS, women who have "at least one child with [ARBD], have also experienced child physical or sexual abuse, domestic violence, generational alcohol abuse, poly-drug use or other traumatic life experiences" (DHSS report, 2000, p. 4). Self-medication with alcohol or drugs as a primary strategy to cope with stress and painful emotional experiences often becomes a lifelong problem for some women (p. 4). In addition, mothers with FAS children had a prior birth rate of 2.8 compared to 1.5 of the overall mothers in the study.

The study purports that the characteristics of "maternal age and prior births" help identify at-risk mothers in Alaska (p. 11).

An obvious concern in a gendered construction of maternal alcohol consumption is the process of socialization within the alcohol dependent mother-daughter relationship. Daughters who become mothers themselves—not having broken away from alcohol abuse—perpetuate the alcoholic family cycle. Unfortunately, some people suffering from FAS/FAE will never be able to fully take care of themselves without state assistance. In fact the effects of a mother's use of alcohol on her child would necessitate "an external brain—beyond childhood, through adolescence, and into adulthood" (Doctor, 2000, p. 115). FAS individuals will need "more guidance and direction than they can provide for themselves" (p. 115). In addition, alcohol dependent women will often cycle in and out of state or locally funded treatment facilities in order to keep their children (p. 116). Since FAS rates are more than doubled in Alaska in comparison to the rest of the U.S., the statistical evidence suggests a partial basis for a gendered construction of alcohol dependence and alcohol abuse in Alaskan women.

Alaska Native Women, Alcohol, & Cultural Dissolution

A final area of concern central to a gendered construction of alcohol dependence in Alaskan women is the Alaska Native perspective and the role of Alaska Native women. Alcohol abuse has taken its toll in the various indigenous cultures in Alaska since the introduction of the substance by Russian and American colonists. Thayne Andersen (1988) in his book, *Alaska Hooch: The History of Alcohol in Early Alaska*, discusses the notion that alcohol was a way of life for early Russians and Americans:

> Russians came to Alaska looking for furs and claimed the land by international law after planting a boundary marker alongside a liquor bottle at the fringes of the new land. Liquor bottles were commonly used to mark boundaries of land claims by both American and Russian colonizers. (p. 4)

Currently in Alaska, it is common knowledge that the people of the various Alaska Native groups have suffered tremendous cultural loss due to the effects of ethnocentric social practices and socially constructed, rampant alcohol abuse in Native communities. According to Andersen, what we know of "Alaska's history until very recently has come from a non-Native point of view . . . without [the Alaska Native] perspective, a study of Alaska's alcohol history is biased and skewed . . . [seen] through the eyes of only one-tenth . . . of the early population of Alaska" (p. 42). Alaska Native communities today are still in a process of seeking cultural reconstitution and balance due to the systematic dissolution of their cultural ideals and ways of being (AFN Report, 1989; ANC Final Report, 1994; Napoleon, 1991; Segal, 1998, 1999, 2001).

Alcohol abuse has played a central role in breaking apart native culture in Alaska (ANC Final Report, 1994). The devastating ramifications of Alaska Native maternal consumption of alcohol (discussed in an earlier section) has prompted a statewide effort to dramatically reduce the incidence of FAS/FAE by treatment interventions aimed toward alcohol dependent Alaska Native women (FAS Surveillance Project, 2001). Alcohol dependence and/or abuse in general as well as alcohol abuse in Alaska Native communities is a learned health behavior, often modeled by one or both parents or one's peers (Segal, 1998, 1999, 2001). Chodorow's ideas regarding the construction of the

mother-daughter (or the mother-child) relationship and its potential for perpetuating negative internalized beliefs regarding patriarchal dominance, abuse, and alcohol dependence and/or abuse applies well to this discussion of Alaska Native women and alcohol dependence and alcohol abuse. There is an old American Indian saying, which "sums up" the cultural expectations of Native women: "women are the carriers of Indian culture" (Medicine, 2001, p. 163). Women are expected to "maintain a family structure" in the "perpetuation of the culture" (p. 163). Medicine reports that there is still much discrimination toward American Indian/Alaska Native women such that "indigenous females are caught in a triple bind of gender, prejudice, and isolation" (p. 164). Alcohol use as self-medication for stress and depression by Alaska Native women often becomes a cyclic reaction to Medicine's notion of a "triple bind" (p. 164), developing into a never-ending cycle of alcohol abuse and ill health.

According to Medicine, "racism, sexism, and classism" are foundational to the "manifestations of disequilibrium" of indigenous societies (p. 202). She makes a clear distinction of the daunting problems that hinder women's physical and mental health concerns: "issues of battered spouses, abused children, alcohol and drug abuse, sterilization, parent abuse, and other features of social disorganization often overshadow adaptive strategies that have allowed for cultural continuity" (p. 202). Unfortunately, positive coping strategies of native peoples have tended to be ignored and not "critically examined" (p. 203).

Another hindrance to effective medical and mental healthcare for indigenous women is the lack of cultural awareness on the part of the healthcare professionals.

Native women in need of mental health counseling "have been frustrated" with ethnocentric, biased healthcare views (p. 203). As a result, Alaska Native women are prone to high recidivism rates (Healthy Alaskans 2010, 2001; Segal, 1998, 1999, 2001). American Indian/Alaska Native women in need of treatment for alcohol dependence "seldom receive hospitalization, detoxification, or counseling for their addictions (Leigh & Lindquist, 2003). Elderly American Indian/Alaska Native women often bear the brunt of child-rearing since their daughters have lost parental rights due to alcohol dependence and/or abuse (IHS, 1991). Alcohol dependence and alcohol abuse are "at the root of many health problems" (Leigh & Lindquist, 2003) suffered by American Indian/Alaska Native women. American Indian/Alaska Native women of childbearing ages,"35-44, had a mortality rate due to alcoholism [sic] of 47 per 100,000 in 1990-1992," (Leigh & Lindquist, 2003)—almost ten times the rate for women of all races in the U.S. The challenges Alaska Native women face in regard to recovery from alcohol dependence and alcohol abuse may be a contributing factor to the perpetuation of an underlying gender construction of alcohol dependence and/or abuse in Alaska Native communities.

The Alaska Native perspective on alcohol and substance abuse calls for a return to Native values and Native healing practices (Napoleon, 1991; People in Peril, 1988; Segal, 1999). The systematic devastation of the various Alaska Native cultures by the effects of Russian and American colonization rendered whole groups of Native people:

> traumatized, leaderless, confused, and afraid, the survivors readily followed the white missionaries and school teachers, who quickly attained a status once held only by the *angalkuq* [shamans]. The survivors embraced Christianity, abandoned

> *Yuuyaraq* [the way of being a human being"], discarded their spirit world and their ceremonies, and buried their culture in the silence of denial. (Napoleon, 1991, p. 12)

Volume I of the Alaska Natives Commission Final Report discusses Alaska Native concerns involving cultural loss and the reinstitution of Native ways of healing whole communities devastated by "violence, alcohol, abuse, and cycles of personal and social destruction" (ANC Final Report, 1994). The Commission found that the following concerns were related to Alaska Native use and abuse of alcohol: (a) used as self-medication, (b) destructive effects on Natives' mental and spiritual well-being, (c) alcohol-related illness and disease, (d) disruption of whole Alaska Native communities, (e) lack of adequate or appropriate treatment, and (f) failure of current regulatory and judicial regimes (pp. 76-77). The Commission concludes that Alaska Native communities need to find their own ways and programs (with the support of government grants) to heal the social problems related to alcohol abuse and substance abuse.

Prevention, treatment, and recovery programs specifically aimed at treating Alaska Native women with children can play a major role in the potential recovery from alcohol and substance abuse in Native communities. Additional research regarding Alaska Native ways of healing alcohol and substance abuse problems can eventually form a legitimate basis for the Alaska Native perspective in alcohol prevention and treatment. Recent alcohol recovery research such as The People Awakening Project at the University of Alaska Fairbanks should help pave the way for proactive change for Alaska Native women. The 3- year project is exploring a strengths-based approach to

alcohol recovery and centralizing Alaska Native ways of sobriety (McNicholas, 2000). The establishment of sobriety within Alaska Native communities centralizes the role of Alaska Native women in regard to cultural maintenance and perpetuation. This perspective of a gendered construction of alcohol dependence and alcohol abuse would seem to logically suggest that a health behavioral shift to sobriety within context to an Alaska Native framework would focus on the roles of women in Alaska Native cultures.

Summary & Conclusion of a Gendered Perspective

A gendered construction of women's abuse of alcohol in Alaska as discussed in this study has been informed by several feminist theoretical viewpoints: power asymmetry in patriarchal societies, muted groups theory, standpoint theory, positionality and co-cultural communication theory. In addition, perspectives from the social construction of reality and the social construction of illness and health behavior have formed a foundation upon which to embed a general understanding of a gendered, social construction of women's alcohol dependence and alcohol abuse. An extension of these ideas also includes the discussion of codependency as a potentially gendered relational phenomenon as related to the traditionally feminine construct of caregiving and nurturing.

Based upon these feminist theoretical perspectives, a socially constructed and gender constructed model of the development of alcohol dependence and alcohol abuse in Alaskan women has been suggested. Four concerns affected by alcohol dependence and alcohol abuse in Alaska, specifically related to women, demonstrate a possible connection to a biopsychosocial, gendered construction of health behavior. Especially,

research has shown that more women than men suffer from the effects of SAD and its related symptoms such as self-medication with alcohol. Domestic violence, intimate partner abuse, and child abuse all seem to have roots in alcohol and drug problems. Additionally, the incidence of maternal alcohol consumption related to fetal alcohol syndrome and alcohol related birth defects in the State of Alaska greatly surpasses findings from the rest of the U.S. Finally, the Alaska Native women's perspective suggests that alcohol dependence and alcohol abuse have been perpetuated in Alaska Native cultural systems devastated by extreme personal and community loss, despair, and prejudice. As Beatrice Medicine (2001) suggests, American Indian and Alaska Native women are ensnared in a "triple bind" (p. 164), simultaneously struggling with the effects of sociocultural bias (p. 164). However, Alaska Native women acting as the carriers of their specific cultural traditions can play a central role in healing the wounds suffered from the effects of alcohol dependence and alcohol abuse in their communities.

An understanding of alcohol dependence and/or abuse regarding women living in Alaska is in part informed from an in-depth look at their social location and their traditionally gendered social roles in relationships within a predominately patriarchal social system such as found in the U.S. in general. A social constructionist perspective toward health behavior indicates that behavior is intrinsically involved with social prescriptions, social practices, and social interactions. In addition, a person's body can be thought of as a "social body" (Lorber, 1997) in regard to illness and health behavior. The added layer of meaning that a gendered construction of health behavior contributes

to the social constructionist viewpoint serves to locate women accurately within context to certain aspects of the development of alcohol dependence and alcohol abuse.

Anthropological Approaches to Drinking & Alcohol Abuse

The consumption of alcohol is an activity universal to most known societies. Since the first human experience with naturally fermented substances people have been compelled to drink alcoholic beverages. The study of the human use of alcohol is complex. According to Heath (1973), alcoholic beverages have been used throughout history as "food, medicine, narcotic, energizer, and aphrodisiac in various contexts" (p. 41). However, the intoxicating effect of alcohol carries specific significance to most human groups as the "best known and most widely used means of altering human consciousness" (p. 42).

The study of alcohol emerged within ethnographic studies in the discipline of anthropology as a result of alcohol's role in the natural everyday life and/or the sacred life in most societies studied. The study of alcohol in diverse societies, thus, became part of an anthropological exploration, which Heath (1973) referred to as "unexpected by-products of . . . ethnographic descriptions of drinking patterns" (p. 42). In this sense, the study of alcohol in human groups encompasses an array of cross-cultural perspectives, which include how, why, when, and where the substance can be used such as the "feelings and rules . . . appropriate with respect to drinking, drunkenness, drunken behavior, or even the drunken individual" (p. 43).

For the past 30 or more years, alcohol studies in anthropology have served to explore alcohol use in diverse societies such as centralizing "nonliterate and non-Western

groups" (p. 45). Especially in North America, alcohol studies have focused on Native American/Alaska Native people in order to describe and understand indigenous alcohol use. And through that process, researchers have systematically dispelled stereotypical ideas regarding alcohol and specific ethnic groups' use of the substance such as the *firewater myth* (Brody, 1971; Douglas, 1987; Heath, 1973, 1987, 1995, 1999, 2000; Kunitz, 1994; Kunitz & Levy, 1971, 1974, 1994; Levy & Kunitz, 1974; Marshall & Marshall, 1990; May, 1999; Medicine, 2001).

An anthropological perspective toward the study of alcohol intersects and often integrates concepts from other diverse disciplinary approaches such as those from Psychology, Communication, Sociology, Social work, and Addiction/Alcohol Studies, and Justice. Anthropologists tend to study alcohol from a "phenomenological approach advocated by social scientists . . . rather than the problem-oriented approach of those concerned with . . . dysfunctional drinking" (SIRS, 2001). In this sense, there is a distinction between alcohol studies that focus on cultural beliefs and behaviors, "paying at least as much attention to 'normal' as to 'deviant' patterns" (SIRS, 2001) compared to studies that situate alcohol dependence and/or abuse as the assumed contributory factor in specific social problems.

The differing units of analysis across the social sciences utilized to study alcohol not only drive the methods used for analysis, but also fuel underlying epistemological perspectives. For instance, a general psychological orientation to the study of alcohol focuses on individual drinking behavior and its antecedents (e.g., dysfunctional family and personal relationships). However, recent trends in psychology, such as portrayed in

the sub-discipline of health psychology, are utilizing a more integrative approach to the study of human health behavior by promoting an alternative epistemological perspective referred to as the "biopsychosocial" model (Brannon & Feist, 2000, p. 11). In this regard, biological and social factors are equally integrated into psychological perspectives of studying human health behavior.

A sociological or social work perspective centralizes a systems approach or an ecological approach in regard to the alcoholic individual's "adaptation" within a system (e.g., a family system or an addiction system) to internal or external stress" (Van Wormer, 1995, p. 7). A communication perspective in the study of alcohol centralizes shared interpretive meaning within social interaction (Denzin, 1987a, 1987b). Here the unit of analysis has shifted away from a focus on *individual behavior* toward an ontological sociocultural framework (Bateson, 1983; Beck, 2001; Berger & Luckmann, 1966; Geertz, 1973; Gergen, 1991, 1999; Gergen & Gergen, 1993; Harré, 1983, 1989, 2000; Harré & Gillett, 1994; Lorber, 1994, 1997; McLeod, 1997; Shotter, 1991, 1993). A social constructionist viewpoint utilized in the study of human communication overlaps with an anthropological perspective in that cultural settings and interpretive practices are constitutive of individual and group behavior. In contrast to the culturally centralized view of human communication and anthropological studies, addiction/alcohol studies and justice perspectives in the study of alcohol tend to focus on a problem-oriented view of the person, semantically characterizing the person as an "addict" (A.A., 1976) or as an "arrestee"(Atwell & Giblin, 2000). Past research efforts of disciplines such as addiction/alcohol studies and criminal justice to describe a person by his or her behavior

can often act to limit, bias, and skew research. Current trends in substance abuse counseling, for example, have purposefully restructured a working definition of the field by making a clear distinction between the notions of "substance *use* . . . , substance *abuse*, and addiction" (Lewis, Dana, & Blevins, 2002). The disciplines of psychology, sociology, social work, health communication, and substance abuse counseling now have shifted toward a more holistic approach in the study of human health behavior by using a biopsychosocial viewpoint (Beck, 2001; Brannon & Feist, 2002; U.S. DHHS, 2000; Lewis et al, 2002). According to Lewis et al. (2002), substance abuse and addiction have "multiple systems interacting both in development . . . and in their treatment" (p. 109). In this regard, most social and human sciences have progressed to an integrative interdisciplinary approach to the study of alcohol.

Changes Within the Anthropological Literature on Alcohol During the Past 30 Years

Since the early 1970s, anthropological research has increasingly applied an interdisciplinary approach to the study of alcohol and culture. A landmark anthropological review of alcohol studies was published in 1973 called, *Cross-Cultural Approaches to the Study of Alcohol: An Interdisciplinary Perspective* (Everett, Waddell, & Heath, 1973), which laid the groundwork for later anthropological studies of alcohol. This anthology includes a "comprehensive bibliography that reflects the breadth and depth of the diverse and widely scattered literature" (Heath, 1973, p. 41) regarding anthropological studies of alcohol. Over 600 alcohol studies spanning two centuries were documented in Heath's review—from 1798 through 1974. These interdisciplinary

approaches on alcohol range from biological perspectives to specific ethnographic studies.

Studies such as *Ethanol Metabolism in Various Racial Groups* (Fenna, Mix, Schaeffer, & Gilbert, 1973) and *Ethnic Groups, Human Variation and Alcohol Use* (Hanna, 1973) sought to integrate biological and cultural perspectives in the study of alcohol. The former study posed a biological hypothesis of alcohol, which attempted to explain differences between racial groups. Hanna (1973) explored the existent literature regarding possible correlations between biological and cultural factors. A brief summary of various research findings suggested there is a genetic link in regard to metabolism that varies cross-culturally (p. 273). According to Hanna, research found that Asians "required less alcohol to produce faster and more pronounced responses" (p. 237). Fenna et al. (1973) explored the rate of alcohol metabolism in various racial groups. They performed medical tests on liver functions and other tests pertinent to the metabolism of alcohol utilizing Eskimo, America Indian, and Caucasian male volunteers (p. 227). The results of these tests showed that the blood alcohol level declined slower in the Native American/Alaska Native group overall than in the Caucasian group. The overall findings indicated that all groups achieved "comparable . . . intoxicating blood levels, but the natives metabolize alcohol at a . . . slower rate than the whites" (p. 234). It was suggested that the difference between groups could be due in part to differing dietary patterns over time.

Anthropological studies focused on Native American/Alaska Native groups have proliferated since the 1970s as well. One early study from the seminal anthology by

Everett et al. explored Navajo drinking behavior in regard to its deviance from middle-class society drinking behavior (Ferguson, 1973, p. 161). Ferguson's study found that Navajo men hit their "peak of heavy drinking" (p. 164) much earlier than whites, 39 years of age compared to mid to late forties respectively. Navajo drinking behavior was observed as performing a social function in that drinking is "an activity which often begins in camaraderie, . . . handclasps, fostering the renewal of old clan ties and friendships and the discovery of new ones" (p. 163). Ferguson suggests that Navajo men's "black-out" behavior gives them a "carte blanche" for bad behavior never negotiated while sober (p. 163). Aside from the demographic collection of data in the study, the pressure to drink through social interaction among the Navajos was a significant finding. Ferguson stated that "refusal of hospitality is something of an affront" (pp. 168-169) among the Navajos. Thus, the social needs and social pressures of the Navajo men were intrinsically connected to their drinking behavior.

Another seminal study that focused on Native American drinking behavior explored adaptive processes of a marginalized rural population of indigenous people. The liberal use of the term "lumpenproletariat" in reference to the "migrant Indian [sic] on skid row" centralized a socioeconomic perspective regarding the struggle for identity of Canadian indigenous people (p. 50). Brody delineated the typical experience of the Canadian indigenous person living on skid row as being a compromise based on the "desire for living in the city with the intense need to avoid a milieu dominated by middle class non-Indians" (p. 71). According to Brody, indigenous people living on skid row have created a subculture mediated by alcohol consumption and criminal activity (p 73).

Brody's utilization of a cultural approach to study skid row drinking behavior was an effective choice in regard to the development of workable solutions to the problems associated with alcohol dependence and abuse in an indigenous population. Dominant white society in North American culture in the past had tried to "fix" the social problems of multicultural others while gazing through ethnocentric lenses. Brody's study provided a practical ethnographic template regarding an accurate cultural understanding to frame potential positive future social action for Native American/Alaska Native drinking problems. Other anthropological studies on alcohol and related topics from the 1970s such as various comparisons of Navajo and Hopi people sought to link attitudes toward drinking with the rates of alcohol-related disease (Kunitz & Levy, 1971, 1974; Levy & Kunitz, 1974).

An anthropological viewpoint regarding "drink" up until the 1970s was often developed through the study of other cultural processes (Douglas, 1987, p. 3). According to Douglas (1987), anthropologists who were exploring other cultural interactions "could not avoid taking note of the importance of drinking in the lives of the people they lived among" (p. 3). The most important notion about alcohol from an anthropological perspective is that its study is not necessarily framed upon the negative aspects of alcohol consumption but rather on other socially and culturally embedded practices involving drinking. And therefore, the study of alcohol in the framework of anthropology tends to be a novel non-pathological approach compared to the plethora of previous epidemiological and sociological studies that have focused on the problems associated with drinking (p. 3). This fresh approach has encouraged researchers of alcohol,

especially those in the social sciences, to initiate the development of practical culturally specific ways to deal with alcohol problems in various communities.

Douglas reviewed different researchers' diverse concepts related to an anthropological approach to alcohol and drink through the articles included in her 1987 anthology, *Constructive Drinking: Perspectives on Drink in Anthropology.* As a result of an anthropological perspective to the study of alcohol, a refreshing twist in research inquiry developed such as a critical investigation of "what is meant by *problem drinking*?" and whose version of "troubles" should be taken, native, non-native, or both (p. 4)? These questions have become foundational to an understanding of how alcohol is used and perceived by various cultural members.

Douglas (1987) is highly critical of ethnographic studies that have sought to disregard "pathology where it seems obvious" (p. 6). In her discussion, she cites James Spradley's ethnography regarding the skid row alcoholic as "these ethnographies of bars and flops fall in some unsatisfactory place between genres . . . not any use at all for getting justice, nor . . . raising the level of understanding of the problems of alcoholism [sic]" (p. 7). From an anthropological approach to alcohol, Douglas suggests that studies focused on the "physical, evolutionary, and socio-cultural processes" involved with the act of drinking, alcohol production, and alcohol as a product would seem to be an appropriate stance for investigation (p. 7). However, she also suggests that relevant questions emerge regarding alcohol that are "on the border of society and biology" (p. 7). A relevant linkage to biology and culture can be found in the notion that "women are habitually excluded from taking strong drink. . . . one might look for an ancient wisdom

which protects the vulnerable fetus" (p. 7). This type of research inquiry seeks to make sense of culturally embedded traditions and beliefs so that they may be applied to and contrasted with current knowledge in regard to alcohol practices.

An all too often neglected aspect of many alcohol studies is the concept of the actual "drinks" (p. 6). Douglas utilized a symbolic interactionist approach by suggesting, "drinks construct the world as it is" (p. 8). This way of thinking overlaps with that of the discipline of Human Communication, which builds on the works of Clifford Geertz , Erving Goffman, George Herbert Mead, Kenneth Gergen, and many others who have written seminal works in their respective fields on the interactive nature of cultural and human meanings.

A final perspective on drinks and alcohol is the function of "ritual," which Douglas referred to as constructing "an ideal world . . . [in which drinks] make an intelligible, bearable world . . . [rather] than the painful chaos threatening all the time" (p. 11). Gusfield (1987) viewed drinking as "a ritual act" (p. 75). All too often studies on alcohol have focused on "drunkenness" (p. 75) rather than the act of drinking. When separating the quality of inebriation from notions of drinking, its symbolic role becomes clearer. The achievement of a drunken state is not the aim of most drinking activity. The symbolic function of drink speaks to the cultural framework within which it is embedded such as the American "coffee break," "happy hour" or the "New Year's Eve party" (p. 81). Abstinence from drinking also makes a symbolic statement regarding the possible attitudes toward alcohol. Gusfield delineated these ideas further by making a connection between concepts of leisure, play, and work with religious ideology (p. 85). Leisure and

play, cast under the shadow of American Temperance, are often linked with an attitude of ungodly behavior. For others who do not subscribe to this ideology, leisure and play function as a "break" or "time-out" from routine or work (p. 86). Despite one's underlying ideology, drink appears to serve as a "symbolic passage" through the various time periods of the American day.

Antze (1987) explored the relationship between religion and alcohol in his study, *Symbolic Action in Alcoholics Anonymous*. Antze (1987) posited that an individual is initiated into a new culture in the process of adapting to AA's organizational prescriptions and expectations. As a result of this induction, one creates a "new identity" (p. 149). This constructed identity becomes the symbolic mechanism for the individual to recreate self as a recovered alcoholic. The notion of a so-called "Geertzean sense" of culture (an interpretation of culture) is a symbolic action within the organization of Alcoholics Anonymous (AA) (p. 149). Other anthropological views of drink and culture include studies such as Bott's work on the Tongan Kava ceremony and Hazan's study of teatime in an elder's day center. All of these studies of drink, whether about alcohol or not, emphasize the construction of human worlds in which drink acts as a conduit to an insulated version of reality, reinforced by the focus on ritualized forms of drinking behavior.

Heath updated his review of the anthropological literature on alcohol by exploring a range of studies including ethnography and sociocultural anthropology to archaeology, physical anthropology, linguistics, and folklore (Heath, 1987, p. 17). The focus of Heath's study was oriented toward the "theoretical and practical implications" of an

anthropological perspective on alcohol use (p. 16). The anthropological literature increased greatly during the decade of the 1970s. Most importantly, Heath suggested that an ethnographic approach to alcohol points to the "realization that many of the outcomes of its use are mediated by cultural factors rather than chemical, biological, or other pharmaco-physiological factors" (p. 19). In conjunction with this aspect of ethnographic views on alcohol, Heath maintains that an analytical attitude framing "the importance of drinking as a *normal* (and not necessarily as *deviant*) behavior has rarely been recognized in other disciplines" (p. 19). This approach casts a different light upon the usual view of alcohol, which is often based upon a problem-oriented approach, especially in regard to epidemiological studies. Also, Heath warns that validity in statistical analysis is often questionable because data collected and transformed into statistical data can often grossly misrepresent the facts. For example, Heath mentions biased collection of statistical data regarding alcohol related crimes on Indian reservations. The high rate of crimes are reported, but what is omitted is the fact that there are repeat offenders and the enforcement of "the minor crime of *drinking in public*" is an ethnocentric reaction to an Indian way of life, a "custom of drinking outdoors" (p. 37). This biased law enforcement attitude toward Native Americans/Alaska Natives coupled with biased, illogical means of interpreting the data does a great disservice toward possible cross-cultural understanding of alcohol use in various groups.

In 1995, Heath completed a review of alcohol and culture from an international perspective. He explored types of drinking across the world as well as theories about drinking, which included notions of social organization (e.g., age, gender, class, caste),

economics and politics, interethnic relations, diet and nutrition, religion and ritual, conflict management, and law (pp. 328-347). In this review, Heath compared ideas about the risks of heavy drinking with benefits of moderate drinking. The majority of cultures report on "the dangers of excessive drinking" (Heath, 1995, p. 350), yet drinking in these cultures is also viewed as positive. Drinking is often considered "an important adjunct to sociability" (p. 350). A cultural perspective toward the study of alcohol indicates that not only is human use of alcohol varied, but is mediated by sociocultural beliefs and practices:

> A literalist could justifiably say that culture does not cause anything--least of all, substance abuse. But it is equally justifiable to say that cultural factors influence virtually all aspects of human lifestyles, and are dramatically apparent in "causing" different populations to use different drugs, in different ways, resulting in different effects and different kinds and rates of associated problems. One of the most compelling aspects of a cultural perspective on substance use is that a single species, *Homo sapien*s, often uses a single substance such as marijuana, coca, ethanol, and opium in so many different ways and with such varied attitudes, values, beliefs, and practices about who should use it, when, in what context, for what purposes, with what outcomes, and so forth. For that matter, culture is equally important in designating who should not use a substance, or when and where its use is inappropriate, as well as what aims and outcomes of use are "excessive," "abusive," or otherwise wrong. (Heath, 1999, p. 175)

In a recent article by Heath (2000), the study of alcohol is delineated through people's contextual use of the substance such as the when do people drink, where do they drink, who drinks, how do they drink, what do they drink, and why do they drink. Drinking behavior is "natural and necessary," but the use of alcohol in drinking behavior is "more hedged about by rules, laws, and understandings about when it's to be done and when it's not to be done" than other types of drinking (Heath, 2000, p. 10). Heath has suggested that drinking alcohol is an "emotionally laden" (p. 10) human activity, which constructs how cultures vary in their use and abuse of the substance.

Three studies in an anthropological anthology by Garine & Garine demonstrate the breadth and range of anthropological studies on drinking such as a study on the biochemical composition of wine (Troncoso, Garcia-Parilla, & Martinez-Ortega, 2001), a study of alcohol consumption on the small island of La Reunion (Hubert, 2001), and a study regarding gender and drink (Abad, 2001). Troncoso et al. (2001) have suggested that wine drinking in moderation is healthy due to nutritional aspects found in wine (p. 119). Hubert (2001) explored alcohol problems on a small island from the perspective of the ramifications of European colonization (p. 226). The fact that heavy drinking was encouraged early in the history of the island had damaging ramifications on the present-day health of the population. Hubert distinguished the problem with alcohol as being connected to the "quantities" drunk and not the traditional ways in which it is consumed (p. 233). She indicates that the media and island politicians depict people who drink alcohol as bad rather than addressing the real problems of social and economic inequality on the island. Finally, Abad (2001) explored cultural attitudes and values related to a

broad range of drinking behavior in Spanish women. According to Abad, food consumption in this culture has been "conditioned by men's preferences" (p. 153). Women in Spanish society tend to reject alcoholic drinks. There is much social pressure for women to avoid drinking alcohol since men tend to believe that "it's not nice to see a woman drinking . . ." (p. 155). In addition, Abad posited that people in this culture do not drink alcohol alone, that drinking is a gendered behavior that is socially constructed (p. 156).

More Thoughts on Gender in the Anthropological Study of Drinking & Alcohol Addiction

An anthropological perspective centralizes gender as a culturally constructed concept (Hartsock, 1983, 1997a, 1997b; Kramarae, 1981, 1996; Lorber, 1994; MacCormack & Strathern, 1980; Moore, 1988; Ortner & Whitehead, 1981; Rosaldo & Lamphere, 1974; Wood, 2001). Even social roles based upon "apparently natural . . . functions" [such as] mothering" or nurturing are culturally created ideas (Moore, 1988, p. 30). According to Moore (1988), any cultural analysis of women and men in regard to what they *do* "inevitably raises questions about the sexual division of labor, . . . and the related division of social life into domestic and public domains" (p. 31). Ethnographers who study women "try to interpret women's behavior as shaped by social context rather than as context free or rooted in anatomy, personality, or social class" (Reinharz, 1992, p. 53).

A feminist Native American researcher, Medicine (2001), has centralized Native American women in her work and explored issues of marginality within the dominant U.S. culture. Concerns for Native women include "adjustment to superimposed policies

of administered human relationships" and the "repression of Native belief systems . . . languages" (p. 163). The notion of retaining cultural knowledge continues to be a major concern for Native women. Women are expected to "maintain a family structure" in the "perpetuation of the culture" (p. 163). Chodorow (1997) supports Medicine's ideas by explicating a psychoanalytic viewpoint of gender construction as grounded in the "mother-daughter relationship" (p. 9). In this sense, women not only learn concepts of femininity from their mothers, they also internalize the social roles and norms for being female in a given culture as interpreted by their own mothers.

In an analysis of work-force issues and Native women and Alaska Native women, Medicine found that in general Native groups have problems "gaining access" (p. 163). In addition, Native women are relegated toward the *helping* human services such as "nursing, teaching, and social work" (p. 163). During the years between 1970 and 1980, Native American women in the work force increased from 35 percent to 48 percent (p. 164). Medicine reported that there is still much discrimination toward Native people and that "indigenous females are caught in a triple bind of gender, prejudice, and isolation" (p. 164). Although Medicine has reported on data over 20 years old, the notion that Native American women and Alaska Native women strive to preserve their various cultures and languages continues to be an important focus in Alaska. Medicine reiterates the role of Native women in the helping and caring professions. She suggests that feminine ways of healing are "grossly overshadowed" in the literature favoring the concept of "medicine men" (p. 197). Also, various tribal demographic data have often been reported in a way that obscures sexual differences in health matters. In tribal

societies such as the Navajo, there has been a shift in wage earning opportunity and power as well as a shift in leadership from women to men. The occurrence of these changes in a traditionally "matrilineal society had impact on the mental health of Navajo women . . . and may be highly conducive to drug abuse" (pp. 197-198). According to Medicine, the "psychological and motivational" aspects of Indian women's lives are the "domains [in which] tendencies toward drug abuse are embedded" (p. 198).

Medicine has indicated that previous research regarding Cherokee women shows their collective "ambivalence" toward the loss of their indigenous heritage (p. 199). Alcohol abuse tends to be connected to this sense of loss in that "normlessness and confusion in role identity . . . is often seen as an impetus to alcohol consumption" (p. 199). She also insisted that it is difficult to "obtain a comprehensive and cogent statement of mental health needs from Native American and Alaska Native women (p. 200). This problem stems from the fact that during the 1970s governmental reports tended not to recognize any gender differences in mental health needs. Due to this dilemma, Medicine found it necessary to gather information while attending national Indian women's organizational meetings (p. 201). Additionally, Medicine found that the changing role of women in Native societies is a major contributing factor toward mental health issues in women (p. 201). Issues such as "dissonances in male-female relationships" (p. 201) resulting in divorce, one-parent families, domestic violence, child neglect, and child abuse pave the way for continuing mental health needs for women.

Another anthropological researcher, Brant (1999), explores First Nations women's writing regarding their "history of revolution, of sorrow, of love" (p. 91). She

contrasts the turn of the century poetry of Mohawk writer Emily Pauline Johnson with the development of Native women's writing through the past century. Native women writers such as Mary TallMountain, an Alaska Athabascan, as well as American Native writers such as Minnie Freeman, Marie Baker, Donna Goldleaf, Chrystos, and many gifted others are mentioned in her article. Native women's writing speaks to nature, the land, love, loss, and despair.

One short section in Brant's article refers to "recovery writing" (p. 98). A Native women writer, Chrystos, a Menominee poet, who writes about recovery, expresses "what it feels like to be hooked and in thrall to the substances that deaden the pain of being Native" (p. 98). Writers such as Sharon Day of the Ojibwa Nation and Two Feathers of Cayuga Nation talk in their poetry about rage, anger, escape, or choosing the spiritual path toward the "Good Red Road" (p. 98). Alcohol and drug addiction are dealt with in Native women's poetry and short stories as the "struggle to stay clean and sober" (p. 98). Brant's own writing about recovery centralizes "the moment between staying sober and taking *just one* drink" (p. 98). Brant sums up this struggle between poor and healthy choices as that "choice to live on the Good Red Road, or to die the death of being out of balance" (p. 98). Brant indicates that Pauline Johnson wrote about the Native dilemma of being victim to whiteman's use of "alcohol as a weapon to confuse and subjugate us" (p. 98). Native women's stories can be powerful tools to awaken other women toward change and personal empowerment.

In contrast to a Native American/Alaska Native women's perspective on alcohol, Eber (1995) explored the relationship between alcohol and women in a Mayan town.

Eber studied perspectives on alcohol from the co-cultural viewpoint of the marginalized people in the community under scrutiny, the "Pedranos" (p.4). These various perspectives come from "colonizers' points view" (p. 3), other anthropologists, and the people in the actual place of study. Eber (1995) states that she centralized the views of the local people, Pedranos, compared to the views of historians and anthropologists. She combined anthropological perspectives on gender and drinking with Pedranos' perspectives on drinking and gender.

An historical approach to the people and locality of Eber's (1995) study indicate Pedrano women, like women in indigenous or European societies, have been seen as "passive victims" (p. 4). This view has been consistent with the ethnocentric biases in reports often framed in Western conceptualizations (p. 4). According to Eber, women's power in this indigenous society was disregarded in preference to "male forms of power" (p. 4). The notion that men may have had little or no "access to the women's world" never crossed the minds of the historians who initially gave accounts of the Pedrano society (p. 4). Eber reminds her audience that feminist researchers "avoid research strategies which lead . . . to generalize from data about men to communities at large" (p. 4). In this sense, she uses a gender framework that centralizes women's points of view in that "gender, itself, is a concept that anthropologists are continually reworking to illuminate its connection to other ways people differentiate themselves, including race, class, caste, and ethnicity. . . . by shedding new light on Western concepts about gender and drinking, including: *self, family, community, power, and dependency*" (p. 4).

Feminist researchers, according to Eber (1995), "draw on the rich legacy of their foremothers . . . as well as insights that women from diverse cultural backgrounds offer" (p. 5). Eber indicates her own strategies focus on the "symbolic and the materialist" (p. 5) women's perspectives with minimal attention to psychological perspectives. A concern to the study of women in particular is the notion that "gender asymmetry and male dominance may be universal" (p. 5). Feminist strategies in research centralize power asymmetry as the basis upon which gendered behavior is constructed (Ardener, 1989; Kramarae, 1981; Hartsock, 1997a, 1997b; Orbe, 1998a, 1998b; Ortner & Whitehead, 1981; Rosaldo & Lamphere, 1974; MacCormack & Strathern, 1980; Wood 1996a, 2001).

Eber (1995) refers to studies by male researchers who have studied drinking from a male context only, but then generalized to include women (p. 8). In retrospect, these researchers agree that their findings may have been skewed regarding men's drinking patterns as being unproblematic due to the tendency to report on men's normative drinking behavior and practices (p. 8). Women's relationship to drinking was not a consideration initially, according to Eber, who has come to understand that "drinking has probably always been more problematic in most societies . . . than seems apparent from the ethnographic records" (p. 8). She asserts that to understand drinking in a given society a researcher must "talk with people of all ages and groups" (p. 8).

Eber (1995) points out that women's and men's drinking is very different in most societies. There are higher "risks and barriers" for women problem drinkers than for men in most Western societies (p. 8). An important consideration regarding the impact of

women's drinking in a given society relates to women's issues such as vulnerability to rape, traditional nurturing roles, and pregnancy (p. 8). Power differentials between men and women as well as gender stereotypes tend to "slight societal and historical processes contributing to alcohol use" (p. 9).

A study by Marshall and Marshall (1990) regarding alcohol prohibition and women in Truk utilized Marshall's earlier Truk study of men's drinking as a baseline. Gender role differences in Truk accounted for opposing views on alcohol. Traditionally, women were second-class citizens in Trukese society; women's roles were culturally constructed as domestic only. Prior to Western introduction of alcohol, Truk had no alcoholic beverages (p. 30). Trukese men learned Western drinking habits in the 1890s from the "resident traders . . . [who] behaved in a rowdy, belligerent manner" (p. 31). Women were not allowed to drink alcohol in Trukese society. Marshall & Marshall (1990) conducted a survey of the Trukese population finding that only 2.3 percent of women used alcohol compared to 85.5 percent of men (p. 7).

Drawing from Edwin Lemert's 1969 seminal work on alcohol and social control, Marshall & Marshall (1990) discuss four models for social control of alcohol: substitution, regulation, education, and prohibition (p. 3). According to Marshall and Marshall (1990), women in Trukese society were believed to be "intellectually inferior and physically weaker than men" (p. 41). Trukese women have had to fight against this stereotype. Women gained the right to vote at the end of World War II. They used their collective voting power to eventually bring prohibition to their communities.

Educational opportunities in Truk were unequal between boys and girls until the later part of the 1960s. After that time period, girls were slowly allowed to get an education. Some Trukese families were reluctant to include girls in education because "sending girls to school wasn't worth as much as sending boys" (p. 43). Marshall and Marshall indicate the fact that girls were prevented from attending school prior to the 1960s had ramifications "still felt 20 years later" (p. 43). However, the eventual inclusion of girls in elementary and secondary education became "a key to a greater women's voice" (p. 45) in Trukese communities. Since the 1960s, more and more women in Truk have become professional and business owners. The combination of increased educational and employment opportunities for women in Truk, has led to a major shift in gender relations. Prior to the change in gender relations, women did not complain about men's drinking problematic behavior in public. Since the power differential shifted between men and women in Truk, women have become more vocal about the problems connected to alcohol use and abuse. Women's organizations, secular and religious, began to grow during the 1960s and 1970s. Women's voices and votes were finally making an impact on a governmental level. The women of Truk were instrumental in voting into law alcohol prohibition through their temperance-prohibition movement. Marshall & Marshall's (1990) research on the women in Truk has become a landmark study in regard to the power of social change in gender relations in a traditional society. The notion that Marshall and Marshall had previously studied men's drinking habits in Truk 15 years earlier, without considering women's attitudes toward drinking, reflects an additional shift in gender focus within the anthropological community. This gender

related change in regard to anthropological study casts a critical eye onto earlier studies on alcohol where men's habits were centralized. The addition of women's perspectives on alcohol has given a more realistic framework upon which to understand cultural use and abuse of alcohol.

Native American/Alaska Native Women & Alaska Native Communities: Views on Alcohol

Medicine (2001) states that the U.S. has "more than five hundred 'federally recognized' tribes" (p. 161) within its borders. In that respect, a researcher needs to study people in their actual tribal context in order to develop an in-depth understanding. According to Medicine, people in the U.S. government and researchers alike tend to refer to the various tribal peoples as simply "American Indians or Native Americans and thus negate the diversity of tribal cultures and characteristics" (p. 161). May (1999) discussed twelve myths regarding alcohol abuse and Native Americans. He suggests that there is "no excuse" basing reports of alcohol use in Native American populations on "myth and common knowledge" (May, 1999, p. 227). Of the twelve myths posed by May, five are of utmost relevance to the study of Alaska Native people: a) are Indian [and Alaska Native] related problems with alcohol uniquely Indian [and Alaska Native]?," b) "is there a higher prevalence of drinking among Indians [Alaska Natives]?," c) "what is the relationship between child abuse, child neglect, and alcohol?," d) "is Fetal Alcohol Syndrome (FAS) a major problem for Indians [Alaska Natives]?," and e) can prevention programs designed for one tribe be adjusted and applied to others?" (pp. 227-228). May suggests that these are "half-truths at best" (p. 228). He posits that public health officials miss three-fourths of the alcohol problem in Native American populations by

concentrating on chronic alcoholic behaviors since the problems with alcohol comprise a broader range of problems and situations.

The notion from earlier studies such as the Fenna et al. (1973) study and the Hanna (1973) study where it was suggested that Native Americans/Alaska Natives metabolize alcohol in a different way than other ethnic groups is mostly unfounded. The unfortunate aspect of this myth is that it is believed by a high percentage of both non-Native and Native Americans. May (1999) suggests, "alcohol metabolism and alcohol genetics are traits of individuals" (p. 229) rather than attributable to specific ethnic groups. A higher prevalence of drinking among Native Americans/Alaska Natives varies across Native American/Alaska Native populations similar to the variation across the general U.S. population. Even so, prevalence in drinking rates changes across time and groups. There is some evidence that rates are increasing in some Native American/Alaska Native groups (p. 230).

According to May (1999), a study in New Mexico regarding the connection between alcohol and child abuse and neglect found that "alcohol seems to be a necessary, but not sufficient condition for child abuse" (p. 236). Native rates of FAS are higher than the general U.S. population: "4.2 per 1,000 compared to 2.2" (p. 237). May stated that the "myths and common understandings about alcohol use among Native Americans are gross oversimplifications" (p. 240). He suggests that more studies need to focus on "empirical fact" rather than "common mythical understandings" (p. 240).

Rates of alcohol-related problems and deaths as well as FAS are much higher in the Alaska Native population compared to the other Native American groups and the

general U.S. population. Due to high rate of maternal alcohol consumption in Alaska and the more than double the incidence of FAS in the Alaska Native population, the State of Alaska conducted a statewide survey of Alaska Native drinking patterns and prevalence rates in the later part of the 1990's. This report is very detailed and thorough in regard to addressing alcohol related health problems in the Alaska Native population. Also, the criteria stipulated in the federal government's Healthy People 2010 campaign to reduce drinking rates in Alaska Native population is well addressed in the Department of Health and Social Services 2000 report. Even though May suggested that statistics on Native American drinking problems and patterns are often misrepresented, he also has pointed out that a critical analysis of alcohol data collected from targeted populations is necessary to understand the real problems.

Klausner and Foulks (1982) completed research that focused on the people of one village on the North Slope of Alaska during a period following tremendous economic and political change. The discovery of oil on the North Slope of Alaska dramatically transformed a primarily subsistence culture into "an American market economy" (Klausner & Foulks, 1982, p. 2). This radical shift, in indigenous people already culturally shocked from the effects of Russian and American colonization, has escalated certain social problems such as abuse of alcohol. Their study explored alcohol use and abuse in relation to oil development and political change within this region. The researchers' aim was to create an understanding of the impact of sudden social and cultural changes on the Inupiat people of this region. There are several concerns regarding alcohol abuse that are relevant to an exploration of an Alaska Native viewpoint

such as the history of the region, the Americanization of the Inupiat, the introduction of alcohol into the region, and the social problems resulting from the alcohol abuse.

Through the Americanization of this region, the Eskimo people have been in a process of adapting to changes in their language use, major changes in social and political power, pressures to conform to foreign religious doctrines, and the introduction of alcohol use. According to Klausner and Foulks (1982), missionary goals in the region cast Eskimo spiritual and religious practices as evil, which has served to rob the Eskimo people of their cultural roots and heritage. Most governmental and political positions as well as business owners in this rural community during the 1970s were non-Natives. A majority were Americans who had moved into the region to profit from the region's natural resources and as a result they had a negative impact on the daily lives of the Eskimos.

The culturally devastating effects of Americanization of the this region is well-known now and has been chronicled in research since the 1980s such as in the 1988 "*A People in Peril*" article published in the Anchorage Daily News. Alcohol use and abuse is one of the so-called perils discussed in this 1982 study. According to Klausner and Foulks (1982) alcohol in this North Slope Alaska Native community is "concomitant with other social and cultural changes" (p. 111). The researchers suggest that not all sudden social shifts in a society "predispose to alcohol abuse" (p. 111). Klausner and Foulks (1982) posit that "shifting behavioral and attitudinal expectations" (pp. 111-112) that are coupled with psychological stress may be linked to changes in drinking patterns. They explored studies, which have focused on "subsistence anxiety" and the resultant

depression from loss of traditional ways (pp. 112-113). The notion that hunter-gatherer type societies have low acceptance for dependent people in comparison to agricultural societies may be involved with social reactions to drinking (p. 113). Additionally, Klausner and Foulks cite a 1959 study by Barry, Child, and Bacon who suggest that "helplessness" as a result of the loss of cultural ways of being set the stage for uncontrolled drinking (p. 113). The authors cite Levy and Kunitz again to support this hypothesis by indicating that problematical drinking in Indian societies is a "retreatist or escapist response to social disintegration" (pp. 113-114).

Additionally, relevant statistics demonstrate that, although Alaska Natives comprise only 17 percent of the population, "they account for 60 percent of all deaths related to alcoholism [sic]"(p. 126) such as deaths from accidents, suicide, homicide, and chronic illness. More recent statistics are available on the State of Alaska's Department of Health and Social Services Division of Behavioral Health website (H&SSDBH, 2003), which indicate a decrease in the percentage of alcohol-related deaths over the past 20 years. Finally, Klausner and Foulks (1982) suggest that there is a "triadic association" (p. 148) among the combined ramifications of "alcohol, social disorganization" with violent death (p. 148) suggesting the need for an assessment of four "strategic problems" with alcohol use and abuse in the North Slope community: fighting, self-estrangement, family strife, and job performance (pp. 202-224). These findings and recommendations have played a role in subsequent research regarding Alaska Native responses to alcohol problems in Alaska Native communities.

The current dialogue in Alaska regarding the systematic dissolution of the various Alaska Native cultures speaks to a view of cultural empowerment. An awareness of the historical origins of current problems in Native Alaska communities, especially in regard to alcohol problems, has prompted many Alaska Native leaders to centralize a push for cultural respect and traditional ways of healing (AFN Report, 1989; ANC Final Report, 1994; Napoleon, 1991; Segal, 1998, 1999, 2001). In support of an Alaska Native understanding of alcohol problems in Alaska Native communities, Native American strategies regarding cultural renewal and the cultural solution to alcohol dependency and/or abuse are on the rise. For example, White Bison, Inc., an American Indian non-profit organization has recently published a book regarding the healing of alcohol problems in Native American communities called *The Red Road to Wellbriety in the Native American Way* (White Bison, Inc., 2002). The author discusses recovery strategies for alcohol addiction such as transforming the wording in the 12 steps of A.A. to a Native American perspective (Appendix E). In addition, White Bison Inc. has suggested that a Native American philosophical and spiritual tradition grounds successful recovery for Native people such as described in the "Seven Philosophies for Native Americans" (Appendix F). The primary philosophies in this viewpoint centralize the intrinsic value of women, children, and family in Native American culture. In this respect, cultural learning that promotes respect for all people, especially respect for women and children, is being reinforced.

A recent example of the notion that alcohol dependence and alcohol abuse are taught and perpetuated within a family system is effectively demonstrated through the

work of Alaska Native writer Velma Wallis. In her autobiographical work, *Raising Ourselves: A Gwich'in Coming of Age Story from the Yukon River*, Wallis (2002) shares her struggle with alcohol:

> I had so much pent-up emotion that had never been expressed, and when I drank all that emotion came out in violent bursts. I was uncontrollable. I wept for my dead father, for my drunken mother, for the past, for the future. . . . Then one day I caught a glimpse of how I might end up if I didn't gain some control over my behavior. . . . With much struggle and resolve, I kept away from those who had inducted me into the drinking scene. That was one thing I had noticed—that they seemed to enjoy adding new people to their drinking circles. . . . Living in Fort Yukon and not drinking or doing drugs meant deciding to be alone. (p. 179)

Wallis regards choosing to drink and stay drunk as "straying from . . . tradition of caring and knowing one another . . . each time we freely gave ourselves over to our addictions, we were less Gwich'in" (p. 205). She supports a view of healing for Alaska Native communities that includes a "healthy balance of the old while we live in the new. . . .[not fearing to] reclaim our past (p. 211). Mihesuah (1999) refers to this concept as "cultural identity, [which] reflects the cultural standards of a society" (p. 14). A strong sense of cultural identity "gives the individual a sense of a common past and a shared destiny" Green, 1995 study (as cited in Mihesuah, 1999, p. 14).

Currently in Alaska, it is common knowledge that the people of the various Alaska Native groups have suffered tremendous cultural loss due to the effects of, among other factors, ethnocentric social practices and socially constructed, rampant alcohol

abuse in native communities. The ideas of Medicine (2001) in regard to cultural expectations of Native women as being "carriers of Indian culture" (p. 163) centralizes the dynamic role of women in Native communities. An important concept in regard to Alaska Native people in recovery from alcohol abuse is the notion of the "cultural appropriateness" of treatment (Saggers & Gray, 1998, p. 185). Although the Saggers & Gray (1998) study was focused on indigenous alcohol problems in Australia, New Zealand, and Canada, their work overlaps with alcohol concerns from an Alaska Native perspective. Treatment programs designed for indigenous people need to "incorporate indigenous understandings of history, society, and culture [such as] acknowledgement of indigenous and colonial histories, of indigenous social organization and activities, and of continuing language and cultural traditions" (p. 186). This perspective supports the Alaska Federation of Natives Report (1989) and the Alaska Natives Commission Final Report (1994) where respect for Native ways of healing alcohol problems in Alaska Native communities is understood and promoted.

Summary & Conclusion of Anthropological Approaches to Drinking & Alcohol Abuse

The study of alcohol from an anthropological perspective developed through ethnographic studies and over the past 30 years has grown quite diverse. The review of alcohol literature by anthropologists Dwight Heath and Mary Douglas has laid a strong foundation toward a wide range of understandings regarding various culture's use of alcohol and of the notion of "drink" (Douglas, 1987). Anthropological studies on alcohol tend to view human drinking behavior as embedded in cultural practices, rituals, and social interactions that are unique to particular groups of people. Since culture is not

static, the anthropological study of alcohol in cultural contexts often reflects change over time in specific groups.

Culturally constructed gender difference regarding the consumption of alcohol and the way in which alcohol is viewed varies cross-culturally. However, studies centralizing women's relationship to alcohol in particular cultural contexts have emerged often to counter-balance alcohol studies completed primarily from a men's point of view. Feminist perspectives such as muted group theory and standpoint theory make salient asymmetrical power structures within culture that perpetuate different social constructions of gender related to attitudes and practices regarding alcohol. In this respect, women often perform a central role in the continuation of cultural practices because of their traditional nurturing role and their standpoint in regard to the embedded patriarchal power structures in most societies.

Anthropological studies on alcohol in regard to Native American/Alaska Native groups have developed over time from often biased and skewed studies, which have focused on questionable statistical data, to more holistic studies inclusive of Native perspectives. In the anthropological works of Beatrice Medicine, Native American/Alaska Native concerns and perspectives have been centralized as an effective way of studying contexts such as alcohol problems in Native communities. Other anthropological researchers have completed ethnographic studies regarding alcohol, which have focused on gender contexts as well as stratified social contexts within specific cultures. Research studies such as Eber's (1995) study on alcohol and Mayan women and Marshall & Marshall's (1990) study regarding changes over time in Trukese

women's political involvement with alcohol prohibition are relevant examples. These studies exemplify descriptively rich portrayals and contextual analyses of the authentic lived experience of cultural members within specific cultures.

An understanding of cultural aspects of alcohol use and alcohol problems in specific groups of people serves to guide the effectiveness of community alcohol prevention and treatment programs. Especially in Alaska where the population is so diverse, the recognition that there are different cultural attitudes and ways of being in regard to alcohol use and alcohol abuse allows for different approaches designed to fit specific groups of people. A prime example is an Alaska Native movement toward promoting Native ways of healing in regard to alcohol problems (Segal et al., 1999). Ideas related to the cultural study of alcohol such as normalized drinking behavior, non-problematical drinking, and abusive drinking patterns can be delineated and applied effectively within context to specific cultural places and people rather than generalized across cultures. In this respect, anthropological studies of alcohol have provided a valuable range of information to the academic literature on alcohol.

Change in Health Beliefs & Health Behaviors

Recent trends in substance abuse treatment centralize a biopsychosocial perspective. Strategies that integrate biological, psychological, and sociocultural aspects of health behavior change tend to be more effective in treating persons with addictions such as alcohol dependence/abuse. According to Lewis, Dana, and Blevins (2002), substance abuse counseling efforts that include a biopsychosocial framework are able to assess individual health behavior risk "through measurement and analysis of historical,

biological, psychological, and social factors" (p. 110). The use of a biopsychosocial model in treatment and relapse-prevention strategies for substance abuse and alcohol abuse provides realistic ways to understand particular people's addiction problems. This multidisciplinary model also serves practical aims in regard to the promotion of positive health behavior change.

Effective treatment and relapse-prevention strategies draw upon a wide range of health behavior knowledge and resources such as training people in life skills and problem solving, health and nutrition, "building psychosocial skills, . . . cognitive coping, social skills, and stress management . . . [as well as focusing on people in context to their specific] social systems, especially the family" (p. 110). In this regard, a biopsychosocial perspective in the treatment and prevention of alcohol abuse is informed in part by theories focused on health behavior change and social learning (Ajzen, 1991, 1996, 2001; Ajzen & Fishbein, 1980, 2000; Bandura, 1986, 1989, 1997, 2001; DiClemente, 1999a, 1999b; DiClemente & Hughes, 1990; DiClemente & Prochaska, 1998; Fishbein & Ajzen, 1975; Marlatt, 1998, Marlatt & Gordon, 1985; MacAndrew & Edgerton, 1969; Miller, 1982, 1985, 1986, 1996; Miller, Andrews, Wilbourne, & Bennett, 1998; Miller & Hester, 1989; Prochaska, 1984; Prochaska and DiClemente, 1983; Prochaska, DiClemente, & Norcross, 1992; Prochaska, Norcross, & DiClemente, 2002; Prochaska, Redding, & Evers, 1997).

Traditional models of alcohol dependence and/or abuse tend to support concepts of the disease model (Jellinek, 1960). The rhetoric of addiction framed as a disease renders the alcohol addicted person as genetically susceptible to its development,

victimized within its development, and in recovery, perpetually one drink away from a full relapse (A.A., 1976; Denzin, 1987a, 1987b; Jellinek, 1960; Lewis, Dana, & Blevins, 2002; Miller, 1986; Miller & Hester, 1989; Marlatt, 1998; Van Wormer, 1995). Alcohol addiction treatment viewpoints vary in focus from an admonition to total abstinence, as found in the disease model approach of Alcoholics Anonymous (A.A., 1976), to a view of controlled drinking, as found in the harm reduction approach (Marlatt, 1998). Alcohol treatment researchers and counselors are currently reinforcing strengths-based approaches and transpersonal spiritual perspectives in recovery from alcohol dependence/abuse (Becvar, 1997, 1998; Gregson & Efran, 2002; Marlatt & Kristeller, 1999; Miller, 1999; Miller & C'de Baca, 2001; Mohs, Valle, & Butko, 1997; Moxley & Washington, 2001; Rapp, 1997; Richards & Bergin, 1997; Tonigan, Toscova, & Connors, 1999; Yahne & Miller, 1999). A.A. has advocated the use of a spiritual perspective in regard to recovery strategies from its inception. Other substance abuse and alcohol abuse approaches recommend the use of culturally appropriate perspectives that allow for diversity in regard to spiritual beliefs and practices (AFN Report, 1989; ANC Final Report, 1994; Coggins, 1990; IHS, 1991, 1998; May & Rodberg, 1998; Medicine, 2001; Segal, Burgess, DeGross, Hild, & Saylor, 1999; Miller & Thoresen, 1999; Thayne, 1997; Wallis, 2002; White Bison, 2002). This study focuses on health belief and health behavior models, social learning, aspects of social support, and the inclusion of spirituality or a transpersonal perspective in the treatment of alcohol problems. The process of recovery is not easy for most people suffering from alcohol dependence/abuse. In order to understand its complexity, an overview of the various perspectives considered

foundational to positive health behavior change can help delineate and demystify aspects of the process.

Alaskan Women & Change in Health Behavior

A woman's entry into recovery from alcohol dependence/abuse represents a radical shift in health behavior (Evans & Sullivan, 1995; Mirkin, 1994; Schaef, 1987; Wilsnack & Beckman 1984). One must be ready to make specific health behavior changes in order to initiate action toward a positive direction in personal health. When health behavioral changes are mandated through the expectations of others such as persuasion from one's spouse or from court orders, the longevity of the change is often compromised by a person's lack of internal readiness. This lack of authentic readiness can be reflected in a person's attitudes, beliefs, and intentions regarding a specific health behavior. Health belief models, which embed the interaction between one's attitudes, beliefs, and intentions, have been developed over time by researchers in medical and social science to study the development of health behaviors. Health communication specialists and health psychologists both study health behaviors in the context of a person's real life such as health behavior related to alcohol abuse and dependence.

Alcohol dependency is a health behavior that is prone to relapse. The risk of relapse exceeds 50 percent in women recovering from alcohol dependence and/or abuse (NIAAA, 2001). The State of Alaska has gathered statistics during the past decade that indicate Alaska surpasses all other states in alcohol abuse—Alaskans are more than twice as likely to abuse alcohol, it is estimated that fourteen percent of the population "abuses alcohol or is alcohol dependent" compared to seven percent in the general U.S.

population (Healthy Alaskans 2010, 2001). In the Alaska Native population alcohol abuse rates are again twice as high as in the general population (DHSS, State of Alaska, 2001, p.17). Chronic liver disease and cirrhosis is listed as the tenth leading cause of death in Alaska (Healthy Alaskans 2010, 2001p. 20). Alcohol abuse is implicated in over "seventy-five percent of child abuse cases and over eighty percent of adult crimes" in Alaska (p. 33).

In regard to alcohol dependence and/or abuse in Alaskan women, the rate of maternal alcohol consumption is twice as high as the rest of the nation. The prevalence rate of FAS and ARBDs in Alaska Native women is 4.8 per 1,000 births—more than four times higher than other Alaskan alcohol dependent women (DHSS, FAS Status Update, 2001, p. 18). FAS and ARBDs are totally preventable yet 14 FAS babies are born each year in Alaska according to the State of Alaska, Department of Health and Social Services. Another factor related to FAS in Alaska involves an older maternal age for women who give birth to FAS babies. Alaskan women from the 30- to 39-year old age bracket had the highest rate of FAS births (DHSS, 2000, p. 10). The authors of the DHSS 2000 report also found that at least sixty percent of alcohol dependent women had lost custody of their children. The statistical rates of alcohol abuse and dependence become more dramatic when comparing the estimated cost of $18,000-$25,000 for treatment for one alcohol dependent woman versus the estimated cost of services provided to one FAS individual—$1.4 million - $3.0 million over a lifetime (DHSS report, 2000, p. 12). Finally, twenty percent of Alaskan women who were alcohol dependent and gave birth to a FAS or ARBD child had previously received treatment for

alcohol dependence and/or abuse (DHSS report, 2000, p. 11). The high recidivism rate for alcohol dependent women is cause for alarm in this state. Especially, since alcohol dependence and/or abuse are preventable and treatable.

Due to the notion that alcohol dependence and/or abuse are relapse prone health behaviors, it would seem necessary to understand how people become ready to make positive health changes. The recovery process is a personal journey into an unknown territory for each woman tempered by her own attitudes and beliefs, her family/social interactions, and her level of desire to enact a positive health behavior change. An exploration of theoretical ideas regarding health beliefs, attitudes, and values provides a health behavior framework with which to understand the addiction and recovery processes.

Health Belief Models

The Health Belief Model (HBM) was developed shortly after World War II by the U.S. Public Health Service to study peoples' health behavior related to participation in disease prevention and detection strategies (Strecher & Rosenstock, 1997, p. 42). Health belief models are part of a general category of expectancy value theories. Expectancy value theories centralize the importance of personal attitudes, beliefs, and evaluations in the process of directing oneself toward certain behaviors. According to Strecher and Rosenstock (1997), the cognitive functioning of individuals "such as thinking, reasoning, hypothesizing, or expecting are critical components of all cognitive theories" (p. 42). Expectancy value theories are in the broad category of cognitive theories and place emphasis on the notion that "behavior is a function of the subjective value of an outcome

and the subjective probability, or expectation, that a particular action will achieve that outcome" (Strecher & Rosenstock, 1997, p. 42). Another central concept of expectancy value theories is the evaluation of costs or gains and benefits of engaging in specific behaviors. Humans are complex and in order to effectively study a person's interpreted meanings regarding his or her health behavior one needs to explore the human contexts of specific health behaviors.

People practice information processing, which is based on the perception and interpretation process. This process involves selecting personally relevant information from horizons of the environment, organizing it based on prior experience, then subjectively/intersubjectively interpreting the information. Basic assumptions of expectancy value theories are that people will anticipate certain outcomes in reference to known understandings and place value on those outcomes. Peoples' behaviors are goal-oriented and reflect specific cognitive functioning toward attainment of those goals such as planning, strategizing, analyzing, and reevaluation.

The Health Belief Model (HBM), a foundational expectancy value theory, is used to "explain change and maintenance of health behavior and act as a guiding framework for health behavior interventions" (Strecher & Rosenstock, 1997, p. 41). The model consists of four beliefs or perceptions: susceptibility, severity, benefits, and barriers. However, there are limitations to the original HBM in regard to cues to action, self-efficacy, intentions to behave, and perceived social norms (pp. 46-49). The model has been further developed through behavioral learning and cognitive research theorists (Strecher & Rosenstock, 1997, p. 42).

The two theoretical health behavior approaches have evolved from the HBM. Ajzen's and Fishbein's Theory of Reasoned Action (TRA) and Ajzen's Theory of Planned Behavior (TPB) add the notion of intention to act or not to act to the original four components of the HBM—susceptibility, severity, benefits, and barriers (Ajzen, 1991, 1996; 2001; Ajzen & Fishbein, 1980; Ajzen & Fishbein, 2000; Ajzen & Sexton, 1999; Fishbein, 1990; Fishbein & Ajzen, 1975; Montano, Kasprzyk, & Taplin, 1997). An additional health behavior approach, the Transtheoretical Model and Stages of Change (TTM), is used to analyze a person's level of readiness along a continuum of adopting health behavior change from pre-contemplation to maintenance and termination (Connors, Donovan, & DiClemente, 2001; DiClemente, 1999a, 1999b; DiClemente & Hughes, 1990; DiClemente & Prochaska, 1998; Prochaska, 1984; Prochaska & DiClemente, 1983; Prochaska, DiClemente, & Norcross, 1992; Prochaska, Norcross, & DiClemente, 2002; Prochaska, Redding, & Evers, 1997). Health belief models help researchers explore and develop understandings of peoples' health behaviors in specific contexts as well as help design specific health interventions and/or preventative strategies such as mediated public health messages. One such context, alcohol abuse and dependency in women, has become a social imperative in Alaska due to the higher than national average of FAS and ARBDs.

Theories of Reasoned Action & Planned Behavior

The Theory of Reasoned Action and Theory of Planned Behavior (TRA/TPB) were both developed in the field of social psychology by Icek Ajzen and Martin Fishbein (Ajzen, 1991, 1996, 2001; Ajzen & Fishbein, 1980; Ajzen & Fishbein, 2000; Ajzen &

Sexton, 1999; Fishbein, 1990; Fishbein & Ajzen, 1975; Montano, Kasprzyk, & Taplin, 1997). The TRA was formulated to explore ways to predict behaviors and outcomes. The TPB evolved later to address limitations in the TRA that did not account for a person's perceived behavioral control (Ajzen, 1991, p. 181). However, both theories centralize a person's "intentions to perform a given behavior . . . [which] are assumed to capture the motivational factors that influence a behavior" (p. 181). The two theories are often represented as one set of theories with the augmentation of perceived behavioral control and power. Therefore, the TRA/TPB are considered as one theoretical perspective for the purposes of this review.

According to the TRA/TPB, a person's behavioral intention is the "most important determinant of behavior" (Montano et al., 1997, p. 86). The underlying components that influence behavioral intentions, attitude, subjective norm, and perceived behavioral control in the theoretical framework of the TRA/TPB are behavioral beliefs, evaluations of behavioral outcomes, normative beliefs, motivation to comply, control beliefs, and perceived power, (p. 92). Ajzen's updated version of the TPB (Figure 2.1) illustrates the complete TRA/TPB model (Ajzen, 1991, p. 182). The augmentation of perceived behavioral control and power account for the notion that "behavioral performance is determined jointly by motivation (intention) and ability (behavioral control)" (Montano et al, 1997, p. 91). The TRA/TPB have added more research depth to the original HBM by including the idea that people are "rational actors . . . all individuals process information and are motivated to act on it" (p. 89). Both the TRA/TPB have

extended the HBM by providing "excellent frameworks for conceptualizing, measuring, and identifying factors that determine behavior" (p. 108).

Conceptual constructs from the TRA/TPB such as a person's attitudes about a certain health behavior, perceived ability to control a certain behavior, and reactions to the opinions of social others can be utilized to develop an understanding of a person's process of recovery from alcohol abuse. A person's readiness to change self-destructive health behavior to healthy behaviors is reflected in his or her beliefs and attitudes regarding a specific health behavior such as recovery from alcohol abuse. A person must make decisions based upon a continuum of subjective/intersubjective choices originating from culturally embedded beliefs and attitudes related to authentic behavioral intentions. When a person enacts a positive health behavioral shift, the new way of being represents the terminus of a very complex process of internal mediation between one's learned and known behaviors, healthy or unhealthy, and acquisition of new, foreign behaviors. According to Ajzen (2001), "people act in accordance with their intentions and perceptions of control over a behavior," prime examples would be a cigarette smoker or an individual abusing alcohol intending to quit their unhealthy behaviors but delaying taking positive action due to a perceived inability to exercise control over the new behavior (p. 43). Perceptions of control can be negatively influenced by self-interpretation of the noise and/or negative self-talk inside one's mind and/or from social others. All the mechanisms that underlie a behavioral intention such as attitudes about self and others in relation to the behavior must shift in order for a person to adopt a new behavior.

People recovering from alcohol abuse and dependence undergo a very personal process toward health maintenance behaviors. There is no one particular way to achieve positive changes in health behavior. In order to understand the personal struggle some people go through to make positive changes in health behavior, we must know their stories of recovery, their intersubjective interpretations of their world, and how they enact their behavioral intentions toward a healthy lifestyle. The constructs from the TRA/TPB form a starting point from which to study mechanisms of change. Most health behavior changes do not follow a linear-sequential process—although, people do appear to travel through distinct levels or stages of readiness while negotiating choices for change.

Transtheoretical Model & Stages of Change Theory

Prochaska's and DiClemente's Transtheoretical Model (Figure 2.2) is a multimodal perspective that has incorporated concepts and processes from a cross section of intervention theories (Prochaska, Redding, & Evers, 1997, p. 60). There are five initial phases to the process: precontemplation, contemplation, preparation, action, and maintenance stage. A sixth stage, termination, was added to address certain situations such as addictions where the individual exhibits "no temptation and 100 percent self-efficacy" in regard to the health behavioral shift (Prochaska et al., 1997, p. 63). A stage model embraces the notion that people can only make effective change when they are ready to do so. In regard to recovery from alcohol abuse and dependence, the later point becomes extremely relevant due to the high recidivism rate in Alaska. According to informal discussions between substance abuse experts in Alaska and the researcher, the overall relapse rate in Alaska is close to fifty percent. The recent trend in substance

abuse treatment leans toward a holistic, person-centered approach with individualized goal setting (Lewis, Dana, & Blevins, 2002, p. 9).

Prochaska et al. (1997) discuss ten processes within the TTM in regard to how people make changes: consciousness raising, dramatic relief, self-reevaluation, environmental reevaluation, self-liberation, helping relationships, counterconditioning, contingency management, stimulus control, and social liberation (pp. 63-64). The shortcomings of this model relate to the type of health behavior changes being made. Prochaska et al. (1997) suggest that more research utilizing "theoretical variables, such as perceived risk, subjective norms, and severity of the problem" could help with the construct of stages by "predict[ing] progress" (p. 80). There are fundamental contextual differences between certain health behaviors such as willingness to get a mammogram versus weight loss or abstinence from substance abuse. The model must be adapted as necessary to accommodate the inherent challenges of particular intended health behavior changes. The sixth phase of the process, termination, applies only to certain types of health behaviors such as abstinence from alcohol or drugs. Termination would not apply to health behaviors such as seeking routine preventative health care or ongoing diabetic care. The Transtheoretical Model and Stage of Change Theory can be an effective way to describe the process that people go through to create positive change. In order for the model to function practically as an actual tool for change, health care professionals need to facilitate and tailor its applicability to specific health behaviors.

Social Cognitive Theory & Self-Efficacy

Self-efficacy is an integral aspect of positive health behavior change and can be found embedded in the constructs of the TRA/TPB as well as the TTM. Bandura introduced the notion of self-efficacy in regard to his extension of Social Learning Theory, which he renamed Social Cognitive Theory (SCT) (Baranowski, Perry, Parcel, 1997, p. 154). SCT (Figure 2.3) attempts to explain human behavior as a "triadic, dynamic, and reciprocal model in which behavior, personal factors (including cognitions), and environmental influences all interact" (p. 153). Bandura's SCT stipulates that human beings centralize cognitive, self-regulatory, self-reflective, and vicarious processes to adapt to development and change in life (Bandura, 1986). A simultaneous interplay of "triadic reciprocality" between cognitions, environment, and behavior acts together to form people's choices, intentions, and actions (Bandura, 1986). This process of self-regulation is the means by which individuals negotiate their behavior in a social world. Bandura refers to this triadic interaction between the environment, behavior, and person factors as "reciprocal determinism" (Bandura, 1986). Bandura (1986) asserts that people develop:

> conceptions about themselves and the nature of things . . . verified through four different processes: direct experience of the effects produced by their actions, vicarious experience of the effects produced by somebody else's actions, judgments voiced by others, and derivation of further knowledge from what they already know by using rules of inference. (p. 27)

Personal health behaviors are enacted through this triadic process through human interaction. One of the variables involved in Bandura's social cognitive model is self-efficacy. Self-efficacy can be defined as "people's beliefs about their capabilities to exercise control over events that affect their lives" (Bandura, 1989, p. 1175). The relevance of self-efficacy toward enacting specific health behaviors becomes more significant as U.S. culture continues to suffer from the ramifications of chronic disease. Chronic diseases such as heart disease, stroke, and cancer are the leading causes of death in the U.S. today resulting directly from unhealthy lifestyle and health behavior choices (Brannon & Feist, 2000, p. 4).

Self-efficacy is considered to be the degree of confidence people have regarding their capability to change (performance) and/or control certain events and behaviors that influence their lives. Bandura (1986) reinforces his ideas on self-efficacy by stating "among the types of thoughts that affect action, none is more central or pervasive than people's judgments of their capabilities to deal effectively with different realities" (p. 21). SCT encompasses influences on a person's behaviors from one's physical and social environment, the context or situation of the environment, knowledge and skill to perform a behavior, expectations and expectancies, self-control, modeling or observational learning, behavioral reinforcements, self-efficacy, emotional coping responses, and reciprocal determinism (Baranowski et al., 1997, p. 157). The concept of reciprocal determinism refers to the process of reevaluation in regard to continued change such as when people who achieve abstinence from alcohol abuse choose not to associate intimately with others still engaged in self-destructive drinking behavior.

The role of self-efficacy in SCT relates to the idea that in order for positive change to take place a person must feel a certain degree of confidence. It seems to operate as a measuring device regarding the level and quality of change and/or the actual change itself. According to Baranowski et al. (1997), people "build self-efficacy" as they gain a greater sense of empowerment and skill regarding a behavior (p. 164). If a person's self-efficacy is low in relation to adopting a specific health behavior then their motivation toward that behavior may be diminished. A self-defeating process is enacted in that "misbeliefs in one's inefficacy may retard development of the very subskills upon which more complex performances depend" (Bandura, 1986, p. 395). High self-efficacy, on the other hand, would tend to increase willingness and motivation toward intended health behavioral goals. For some people successful health behavior change comes as part of the natural process of building a sense of high self-efficacy. Bandura (1986), sums this point up very effectively:

> Perceived self-efficacy also shapes causal thinking. In seeking solutions to difficult problems those who perceived themselves as highly efficacious are inclined to attribute their failures to insufficient effort, whereas those of comparable skills but lower perceived self-efficacy ascribe their failures to deficient ability. . . . People who regard themselves as highly efficacious act, think, and feel differently from those who perceive themselves as inefficacious. They produce their own future, rather than simply foretell it. (pp. 394-395)

Self-efficacy also factors into the processes of the TRA/TPB, though, it is not explicitly stated in the model constructs. Behavioral change according to these two models is the

result of an intended behavioral change, which is influenced by several factors such as beliefs, attitudes, subjective norm (social opinion and influence), as well as by self-efficacy effects toward particular aspects of each part of the process. The perceived behavioral control and power in the TPB/TRB relate directly to issues of self-efficacy since a perception of control over a behavior is contingent upon one's capability to perform the necessary skills (self-efficacy) to maintain control. Self-efficacy can be understood in the constructs of the TRA/TRB in regard to the action taken from behavioral intention. Once again, one's confidence (self-efficacy) in ability to strive toward an intended goal or outcome will determine the action taken.

The TTM utilizes the concept of self-efficacy in its discussion of model constructs as well (Prochaska et al., 1997, p. 62). In the process of change between stages of development from precontemplation, contemplation, preparation, action, and to maintenance, a person must deal with their levels of confidence or self-efficacy in order to avoid temptation to backslide into unhealthy behaviors. Self-efficacy here would seem to be a predictor one way or the other of one's capability to withstand the temptation to reenact unhealthy behavior.

Women who abuse alcohol make an unhealthy choice by risking the potential destruction of specific aspects of their lives such as their health, their personal relationships with family and friends, eventually their jobs, and their spiritual integrity. A woman's degree of self-efficacy toward abstinence of alcohol during her early recovery stage will determine specific personal health outcomes. And, if she is pregnant, her baby could suffer as well from fetal alcohol syndrome (FAS), fetal alcohol effects

(FAE), and other alcohol-related birth defects (ARBDs). An increase in self-efficacy toward abstinence from alcohol for a woman at-risk would increase her chances in maintaining a healthy lifestyle. However, because of the resistant nature of addiction, a real dilemma can exist in regard to facilitating a woman's health behavior change for the better when alcohol dependency and/or abuse are involved.

Baranowski, Perry, and Parcel (1997) discuss the possibility of behavior change through the function of increased levels of self-efficacy. Success in behavioral change can take place in "small steps" targeting the specific health behavior to be changed (Baranowski et al., 1997, p. 157). Other integral aspects of SCT pertaining to positive health behavior change are observational learning (modeling) and reinforcement (operant conditioning), which serve to provide exemplars of appropriate behavior and feedback (p. 161). People with destructive addictive health behavior need well-defined health enhancement goals through modeling and consistent positive reinforcement for correct behaviors in order to initiate and maintain health behavior change. According to Bandura (1986), specific goals are necessary for a shift in behavior since "discrepancies between self-efficacy judgment and performance will arise when either the tasks or the circumstances under which they are performed are ambiguous" (p. 397). Bandura (1986) clarifies this concept further by positing "when people are not aiming for anything in particular or when they cannot monitor their performance, there is little basis for translating perceived efficacy into appropriate magnitudes of effort" (p. 398). Therefore, specified health-seeking goals should be set for those individuals in need of positive health behavior change such as women who are at risk to abuse alcohol.

The SCT has been extended by the addition of an "agentive perspective" in regard to health behavior change (Bandura, 2001). Bandura suggests four perspectives of human agency, which influence decision-making and goal-setting: a) intentionality, b) forethought, c) self-reactiveness, and d) self-reflectiveness (pp. 6-10). The notions of intentionality and forethought are particularly important to health behavior change because they perform the function of rendering a person ready to make specific changes. According to Bandura (2001), people make plans before they act through:

> intentions . . . . Future-directed plans are rarely specified in full detail at the outset. It would require omniscience to anticipate every situational detail. Moreover, turning visualized futurities into reality requires proximal or present-directed intentions that guide and keep one moving ahead. (p. 6)

Forethought is another component of human agency and is related to intentionality. Bandura suggests the notion that "through the exercise of forethought, people motivate themselves and guide their actions in anticipation of future events. When projected over a long time course on matters of value, a forethoughtful perspective provides direction, coherence, and meaning to one's life" (p. 7). In regard to health behavior change, a person must exercise an intention to change (make a plan) and use forethought (visualization) to prepare for eventual action.

The relevancy of increases in self-efficacy and the creation of a clear plan and goal toward abstinence of alcohol consumption by women who have a history of alcohol abuse and/or who are pregnant seems to be an obvious health intervention strategy. A viable solution, then, in regard to an effective intervention, would be to determine what

strategy could best enable an increase in self-efficacy for women at risk for maternal alcohol consumption. Most people can be encouraged to modify their behavior as a result of "judg[ing] their capabilities partly by comparing their performance with those of others" (Bandura, 1986, p. 403). The social environment is an integral area within the triadic functioning of the SCT that can act upon a person's cognitions and behavioral outcomes, especially for those people who lack social support.

Social Support

The importance of social support in regard to positive health behaviors cannot be over emphasized (Bandura, 1986, 1989, 1997, 2001; Broman, 1993; Cohen, Gottlieb, & Underwood, 2000; Josselson, 1995, 1996; Lakey & Cohen, 2000; Lorber, 1997; McLeod, 1997; Segrin, 1992, 2000; Thompson, 1995; Trinh, 1998). The concept of social support as it relates to individual behavior includes emotional and material supports from others. A person who lacks social support is considered to be socially isolated, disconnected from a so-called supportive environment. People who are fortunate enough to "receive high levels of social support are usually healthier than those who do not" (Brannon & Feist, 2000, p. 204). A relevant study on social support and health-related behaviors indicates that socially isolated people tend to use unhealthy coping strategies in relation to stress such as cigarette smoking and alcohol use/abuse (Broman, 1993). These poor health behavioral choices eventually have a negative impact on a person's health as well as the health of others such as suffered from environmental smoke or alcohol-related birth defects.

A study examining women's choices involved in maintaining self-esteem analyzed several emergent themes from interview data, one of which is "communicating and learning in relationships" (Chatham-Carpenter & DeFrancisco, 1997, p. 170). The give and take of relationships help women build and maintain self-esteem (p. 170). One of the interviewees in this study indicated that she felt better when helping others because "happiness is a byproduct of making someone else happy" (p. 170). It almost goes without saying that when people feel good about themselves they are generally healthier and happier. Social support can have this affect by providing ways for people to "get outside" themselves and to serve others. But, social support is also a reciprocal synergistic process. For instance, people involved in a therapeutic support group would all tend to benefit from the interactions between members, even if some of the group members were simply observing.

Horowitz (2001) discusses two dimensions of social support, communion and agency (p. 50). Members of a support group would benefit from both types of support such as experienced with a communion style of support, "acceptance and a sense of belonging" and with an agency style of support, enhancement of a "sense of competence and efficacy" (p. 50). Individuals with addictive behavior who participate in support group functions would tend to show an increase in self-esteem as well as in self-efficacy. Another study by Trinh (1998) examined the role of social support in the lives of pregnant women in recovery from addiction. According to Trinh (1998), women who abuse drugs and alcohol "often lack adequate social support systems, including close friends and supportive husbands or boyfriends" (p. 107). These women tend to identify

their social network as other substance abusers or as partners who also are drug or alcohol dependent (p. 111). Self-in-Relation Theory or a relational model posits that the nature of a woman's relationships will shed light on her addictive behavior (Finkelstein, 1996; Trinh, 1998). The notion of relationships as connections and disconnections are foundational to a relational model because women tend to "develop self-esteem and a shared understanding and growth with another individual . . . thus connection occurs when individuals in a relationship experience mutual growth, empathy, and intimacy" (Trinh, 1998, p. 113). Trinh indicates that chemically dependent women are often socially isolated, which would centralize their need for some form of social support (p. 114). Social support for chemically dependent women could involve self-help groups. Self-help groups utilize "peer role models" (p. 114), who function to nurture self-disclosure of sensitive issues and who form the basis of a new positive social support mechanism for the woman addicted to drugs or alcohol.

The value of self-help social support groups for women who abuse alcohol can provide the necessary impetus for positive health behavior change. Cohen, Gottlieb, and Underwood (2000), indicate there are specific underlying mechanisms for change inherent in social network systems such as "social controls and peer pressures that influence normative health behavior" (p. 11). Rapping (1996) adds support for the importance of self-help and social networks in her book *The Culture of Recovery* where "recovery-talk" on television provides a means of social support easily accessible to and targeted toward women at home (p. 15). In addition, social network connections can provide "multiple sources of information . . . thereby increas[ing] the probability of

having access to an appropriate information source" (p. 11). Cohen et al. (2000) offer three hypotheses in regard to social support and its positive affect on people's health behaviors:

> a) socially integrated people have more diverse self-concepts (parent, friend, worker, and member of a church), and this diversity makes stressful events in any one social dimension (e.g., at work) less important, b) socially integrated people have a more diverse resource pool to call on when under stress, and c) socially integrated people have a better quality and greater quantity of social interactions, resulting in increased positive affect and decreased negative affect. (p. 15)

Finally, credence for centralizing social support in regard to promoting positive health beliefs and behaviors can be understood from California's "Friends Can Be Good Medicine" campaign conducted in the 1980s. This particular health campaign was a comprehensive multi-media and social support campaign to study the impact of perceived affect of social support on individuals' health beliefs, importance of relationships, behavioral intentions, and actual health behaviors (Hersey, Klibanoff, Lam, & Taylor, 1984). The general theoretical basis of this public communication health campaign was the notion that social support could be used to "reinforce positive health behavior changes" (p. 293). One of the outcomes from the study indicates that people who lack social skill, who may be socially isolated, or who have experienced a recent trauma such as a death of a close loved one were positively affected by campaign messages and showed the greatest gains from social support (p. 293). The underlying principle from this outcome could be translated to people with specific health behavior concerns such as

maternal alcohol consumption during pregnancy. People with alcohol or drug related problems tend to be socially isolated and/or socially embedded in a negative subcultural environment (e.g., drug culture or bar culture), which tends to perpetuate their addiction or increases their risk for relapse. A positive social environment such as provided in a controlled therapeutic or quasi-therapeutic social support group facilitates healthy behavioral change.

Summary & Conclusion of Change in Health Beliefs & Health Behaviors

Recovery from addiction is a process enacted over time. Theoretical concepts in addiction treatment and recovery strategies such as the study of health belief models and the impact of social support help foster an in-depth understanding of health behavior change. The notion that people often resist change based upon their entrenched attitudes, values, and beliefs has led health behavior researchers to create models for change. The transtheoretical model of change provides a logical framework in regard to the stages people go through while making significant health behavior changes. The components of the theory of reasoned action and planned behavior include ideas about the influence of social norms and degree of personal control in regard to health behavior change. In addition, social cognitive theory provides insightful constructs related to recovery such as self-efficacy, intentionality, and forethought to health behavior change understandings. Finally, the importance of social support as a mechanism of personal change has become a central concept in regard to addiction treatment and recovery strategies. An aspect of successful recovery from substance abuse and alcohol abuse not fully discussed in this study yet relates to transpersonal perspectives. This viewpoint has become more popular

within the fields of mental health and substance abuse counseling over the past 20 years. A transpersonal perspective draws upon a person's strengths in recovery either by reinforcing strongly held personal/cultural spiritual beliefs or by creating a sound base for the potential growth of a person's spiritual awareness of and connection to a greater reality.

The Inclusion of Spirituality: Transpersonal Recovery Perspectives

The ideas of Carl Rogers have profoundly influenced the study and practice of therapeutic counseling. A client- or person-centered approach to therapy suggests that people "have within themselves vast resources for self-understanding and for altering their self-concepts, basic attitudes, and self-directed behavior" (Rogers, 1980, p. 115). A person is better able to access "these resources . . . if a definable climate of facilitative psychological attitudes can be provided" (p. 115). Rogers' (1980) therapeutic viewpoint centralizes concepts directed toward others such as genuineness, acceptance, caring, prizing, and empathy (p. 115). There is an underlying sense of spirituality in his person-centered viewpoint that he speaks to by:

> . . . hypothesizing that there is a formative directional tendency in the universe, which can be traced and observed in stellar space, in crystals, in microorganisms, in more complex life, and in human beings. This is an evolutionary tendency toward greater order, greater, complexity, greater interrelatedness. In humankind, this tendency exhibits itself as the individual moves from a single-cell origin to complex organic functioning, to knowing and sensing below the level of consciousness, to a conscious awareness of the organism and the external world, to a transcendent

> awareness of the harmony and unity of the cosmic system, including humankind. . . . It definitely forms a base for the person-centered approach. (p. 133)

Rogers asserts that there is a "formative tendency at work in the universe" (p. 124), which suggests a greater reality or a higher universal consciousness. Additionally, the work of theologian Martin Buber has influenced the areas of ethical communication and counseling in regard to promoting a profound sense of interpersonal respect among people in dialogue (Buber, 1970). This way of relating with others is referred to as dialogic communication and is based upon six characteristics of ethical communication with others, which include a spirit of: authenticity, inclusion, confirmation, presentness, mutual equality, and a supportive climate (Johannesen, 1990). Rogers' (1980) and Buber's (1970) ideas about ethical interaction with others places the practice of spirituality into everyday encounters, which are especially critical in close relationships such as between spouses, children/parents, friends, co-workers, as well as in professional and/or medical interactions.

A person's capacity to experience a sense of ineffable reality in everyday life is fundamental to a transpersonal perspective in therapeutic strategies for recovery. Transpersonal inquiry and methods refer to "any experience that is transegoic, including the archetypal realities of Jung's collective unconscious as well as radical transcendent awareness" (Valle & Mohs, 1998, p. 99). Moxley and Washington (2001) refer to a transpersonal perspective in therapy as the "fourth force" (p. 252) because it allows both practitioner and client to explore meaning in a greater context outside themselves. According to Moxley and Washington (2001), the utilization of a transpersonal

perspective in recovery offers a person "a sense of their own development as part of the greater cosmos without limiting it exclusively to their search for security, comfort, or even self-actualization" (p. 253). The premise for a transpersonal perspective in recovery strategies has three foundational qualities suggested by Moxley and Washington, which are: (a) teleology, (b) metanoia, and (c) praxis (p. 253). The teleological quality relates to a person's capacity to seek an experience of greater good in life regardless of personal background and history (p. 253). A metanoic viewpoint suggests that people can "adopt values that serve a higher order . . . and [that people] are inherently ethical" (p. 254). And finally, the notion of praxis suggests that a person's recognition of a higher order to the world can be enacted in daily life through "the integration of self-reflection and personal action" (p. 253). A spiritual or transpersonal perspective suggests that people create their own sense of these three qualities as they progress through the recovery process.

Mohs, Valle, and Butko (1997) refer to transpersonal perspectives in the treatment of substance abuse as "honoring the need to integrate ones' personality and yet move beyond and through the personality in order to become aware of one's essence . . . the relationship between ego identity and spiritual essence is, therefore, central to this approach" (p. 1). Mohs et al. point out that the 12-step program of A.A. follows a transpersonal approach to recovery in that it views "addiction as a disease of the Spirit and recovery as a spiritual process" (p. 3). Antze (1987) posits that a person is initiated into a new culture in the process of adapting to A.A.'s organizational prescriptions and expectations. And as a result of this induction, one creates a "new identity" based upon

the recognition of self as part of a greater reality (p. 149). This restructured (spiritualized) identity becomes the symbolic mechanism for the individual to recreate self as a recovered alcoholic. A transpersonal perspective in recovery, thus, centralizes a person's sobriety as a journey inward toward a connection with the "divine, spiritual, sacred, transcendent, the higher Self, or God . . . [wherein] recovery becomes a spiritual process that leads one to inner wholeness and unity" (Mohs et al., 1997, pp. 3-4).

Spiritual or transpersonal perspectives in recovery from alcohol abuse have emerged out of a "strengths" viewpoint of treating the recovering person (Moxley & Washington, 2001). A strengths-based approach to substance abuse and alcohol abuse suggests that treatment efforts in recovery are most effective when they include a person's "strengths, abilities, and assets" (Rapp, 1997, p. 79). In this sense, a person's cultural background and religious and/or spiritual training is a personal strength that can provide support for a reconstruction of the self. This viewpoint embraces diversity as a necessary aspect of personal recovery. Saleebey (1997) posits an additional view of personal strengths that can be called upon in recovery, which he refers to as a "lexicon of strengths" (p. 8) including: (a) empowerment, (b) membership, (c) resilience, (d) healing and wholeness, (e) dialogue and collaboration, and (f) suspension of disbelief. According to Saleebey, people have the ability to heal themselves—there is an "inborn facility of the body and the mind to regenerate and resist when faced with disorder, disease, and disruption . . . so healing and self-regeneration are intrinsic life support systems" (pp. 9-10). An implication in this viewpoint suggests that there is order in life guided by a transformational universal intelligence.

Miller and Thorensen (1999) posit three domains that form a general view of spirituality in regard to therapeutic strategies, which are one's spiritual (a) practices, (b) beliefs, and (c) experiences (p. 7). This diversity viewpoint is foundational to a spiritual perspective in treatment in that "a psychosocial perspective . . . is sensitive to cultural, ethnic, socioeconomic, and religious differences" (p. 7). According to Miller and Thorensen (1999), research, where spiritual and religious aspects have been measured in regard to health, a "surprising consistency [has] been found to be positively related to health and inversely related to disorders" (p. 11). Miller and C'de Baca (2001) refer to the transforming power of spiritual and/or religious insight as "the mystical type of quantum change" (p. 71). Miller and C'de Baca (2001) discuss the notion of quantum change in regard to recovery from alcohol as a "realization that you can't do it on your own, and you open yourself up to the possibility that there's something else there—[you] turn around (or [are] turned around) at the point of hitting the bottom" (p. 24). This viewpoint suggests that a person is *out of control* as well as must *let go* of the illusion of control in order to heal. A.A. jargon refers to this notion as "let go and let God" (A.A., 1976). A.A. conceptualizes God as one's personal higher power in that there is no "need to consider another's conception of God . . . [one's] own conception . . . is sufficient" (A.A., 1976, p. 46). According to Tonigan, Toscova, and Connors (1999), the type of spirituality encouraged in A.A. can be "viewed as a protective mechanism against relapse and . . . serves as a template for conducting daily life" (p. 117).

In contrast, an Eastern spiritual perspective toward recovery from addiction places a person's substance abuse actions "on a continuum ranging from minor to major

problems . . . . the definition of Taoism as the Middle Way [suggests that a person should seek] a position of balance between the extremes of self-indulgence (addiction) and absolute self-denial" (Gregson & Efran, 2002, p. 3). Rather than an acceptance of powerlessness as found in the tradition of A.A., Taoism and Buddhism encourage personal responsibility and accountability. The notion of being responsible and accountable for one's actions "involves acknowledging and appreciating who we are—biologically and psychologically—and using that information to advance our goals" (Gregson & Efran, 2002, p. 61). According to Dreher (2000), a Taoist spiritual perspective underscores an attitude of empowerment in that:

> The Tao asks us to take responsibility for our lives, to follow its path of action and contemplation. Through a shift of attitude, we can begin to experience greater peace right now. By seeing the larger patterns, we can take effective action, moving beyond competition to cooperation, harmonizing with the natural principles underlying all existence from the smallest cell to the largest social organism. (p. 4)

Miller and C'de Baca (2001), suggest that people can draw upon "a great pool of collective, ancestral wisdom akin to what Jung called the collective consciousness [and] within nondeistic religions such as Buddhism, one experiences a sacred oneness with all of nature" (p. 173). Being able to cultivate this deep sense of harmony with nature can help a person who is in recovery from alcohol dependence/abuse to achieve a state of detachment from troublesome thoughts and emotions associated with alcohol addiction. Gregson & Efran (2002) refer to the practice of detachment as being able to increase "the range of positive possibilities and eliminate much of the heaviness . . . it is not that

detachment prevents upsets. . . . However, the practice of detachment renders upsets less overwhelming" (p. 92). Another characteristic of a Taoist viewpoint encourages the practice of moderation in daily life (Dreher, 2000). A commitment to the practice of moderation would seem to preclude or eventually eliminate addictive behaviors. Although the daily practice of Taoist philosophy does not directly forbid the consumption of alcohol, its four principles of oneness, dynamic balance, cyclical growth, and harmonious action along with the six practices of selflessness, moderation, embracing the mystery, non-contrivance, detachment, and humility seem to foster a healthy lifestyle free from substance abuse (Dreher, 2000; Gregson & Efran, 2002). Cloud & Granfield (2001) offer five criteria for "living without addiction" (p. 202), one of which includes building a spiritual base through "maintaining a sense of Well-Being" (p. 203). They suggest that the recovering person can begin a journey of "self-improvement" by starting with "inspirational books by the Dalai Lama, Thomas Merton, and Deepak Chopra" (p. 220). All of the previously mentioned authors share and advocate an Eastern spiritual viewpoint toward recovery from alcohol problems. An Eastern philosophical perspective toward a person's ultimate experience of peace, happiness, and personal balance (control) suggests that "only an individual's own understanding—attained through an educative process undergone with systematic effort, penetrated with creative intelligence, in a context of individual liberty—can lead to the enjoyment of peace" (Thurman, 1998, p. 120). Thurman (1998) refers to this state of personal empowerment as "transcendental individualism" (p. 120), which is a way of being that fosters the positive perspectives on

life necessary to enact and maintain recovery from addictions such as alcohol dependence/abuse.

Marlatt and Kristeller (1999) advocate the utilization of "meditation and mindfulness" (p. 67) techniques as a recovery approach to alcohol addiction. This type of meditative technique originated from an Eastern spiritual tradition. They describe mindfulness as being "fully mindful in the present moment . . . aware of the full range of experiences that exist in the here and now" (p. 68). Two processes involved in concentrative and insight meditation are identified by Marlatt and Kristeller (1999) as being central to treatment for addictions: (a) "the direct experience of 'impermanence' or the constantly changing nature of perceived reality, and (b) the ability to self-monitor subjective events from the perspective of an objective or detached observer" (p. 70). Marlatt and Kristeller (1999) suggest that the application of meditative strategies in the recovery process perform the following functions: "(a) . . . physiological relaxation . . .; (b) . . . changing neurological function; (c) . . . positive addiction; (d) . . . metacognitive intervention; and (e) . . . promoting spiritual and existential growth" (p. 72). The notion of "urge surfing"(Marlatt, 1994) was developed as a meditation technique regarding treatment for addictive behaviors such as alcohol addiction. According to Marlatt and Kristeller (1999), this treatment strategy was "designed as a relapse prevention method . . . to help clients cope with craving or urges that otherwise might trigger a setback or lapse" (p. 78). Additional systematic and rigorous research regarding the relationship between "meditation practice, spirituality, and therapeutic healing" (p. 81) needs to be

conducted in order to fully establish the validity of meditative strategies for recovery from addictions.

Richards, Rector, and Tjeltveit (1999) advocate the use of spirituality in psychotherapeutic treatment as a facilitative method in regard to a person's capacity for "healing and growth" (p. 133). In the past, the concept of ethical relativism in regard to therapeutic strategies rendered people's personal values "irrelevant to mental health and therapeutic change" (p. 134). According to Richards, Rector, and Tjeltveit (1999), ethical relativism is losing favor with contemporary mental health professionals (p. 136). An opening now exists for the scientific exploration of spiritual strategies in the psychotherapeutic treatment, which includes treatment for alcohol dependence/abuse.

Native American & Alaska Native Ways of Healing

Medicine (2001) states that the U.S. has "more than five hundred 'federally recognized' tribes" (p. 161) within its borders. In that respect, a researcher needs to study people in their actual tribal context in order to develop an in-depth understanding of specific native ways of healing. According to Medicine, people in the U.S. government and researchers alike tend to refer to the various tribal peoples as simply "American Indians or Native Americans and thus negate the diversity of tribal cultures and characteristics" (p. 161). Historically in Alaska, the dominant Russian and white American cultural viewpoints have overshadowed and/or obliterated Alaska Native perspectives (Anderson, 1988, p. 42). Alaska Native communities are still suffering the effect of cultural dissolution, despair, and hopelessness (AFN Report, 1989; ANC Final Report, 1994; Napoleon, 1991; Segal, 1998, 1999, 2001). However, many Alaska Native

communities are beginning to claim their responsibility toward promoting Native ways of healing and supporting healthy lifestyles for the people free from alcohol dependence and/or abuse. Wallis (2002) regards choosing to drink and to stay drunk as "straying from . . . tradition of caring and knowing one another . . . each time we freely gave ourselves over to our addictions, we were less Gwich'in" (p. 205). She supports a view of healing for Alaska Native communities that includes a "healthy balance of the old while we live in the new. . . .[not fearing to] reclaim our past (p. 211). Mihesuah (1999) refers to this concept as "cultural identity, [which] reflects the cultural standards of a society" (p. 14). A strong sense of cultural identity "gives the individual a sense of a common past and a shared destiny" Green, 1995 study (as cited in Mihesuah, 1999, p. 14).

Currently in Alaska, it is common knowledge that the people of the various Alaska Native groups have suffered tremendous cultural loss due to the effects of ethnocentric social practices and socially constructed alcohol abuse in native communities. The Alaska Native perspective on alcohol and substance abuse calls for a return to Native values and Native healing practices (AFN Report, 1989; ANC Final Report, 1994; Kawagley, 1995; Medicine, 2001; Napoleon, 1991; People in Peril, 1988; Segal et al., 1999; Wallis, 2002). The systematic devastation of the various Alaska Native cultures by the effects of Russian and American colonization rendered whole groups of Native people:

> traumatized, leaderless, confused, and afraid, the survivors readily followed the white missionaries and schoolteachers, who quickly attained a status once held only by the *angalkuq* [shamans]. The survivors embraced Christianity, abandoned

Yuuyaraq [the way of being a human being"], discarded their spirit world and their ceremonies, and buried their culture in the silence of denial. (Napoleon, 1991, p. 12)

Volume I of the Alaska Natives Commission Final Report discusses Alaska Native concerns involving cultural loss and the reinstitution of Native ways of healing whole communities devastated by "violence, alcohol, abuse, and cycles of personal and social destruction" (ANC Final Report, 1994). The Commission found that the following concerns were related to Alaska Native use and abuse of alcohol: (a) used as self-medication, (b) destructive effects on Natives' mental and spiritual well-being, (c) alcohol-related illness and disease, (d) disruption of whole Alaska Native communities, (e) lack of adequate or appropriate treatment, and (f) failure of current regulatory and judicial regimes (pp. 76-77). The Commission concludes that Alaska Native communities need to find their own ways and programs (with the support of government grants) to heal the social problems related to alcohol abuse and substance abuse.

Prevention, treatment, and recovery programs specifically aimed toward Alaska Native people tend to be more effective when centralizing the various spiritual views of the differing Alaska Native groups. Additional research regarding Alaska Native ways of healing alcohol and substance abuse problems can eventually form a legitimate basis for the Alaska Native perspective in alcohol prevention and treatment. An important concept in regard to Alaska Native people in recovery from alcohol abuse is the notion of the "cultural appropriateness" of treatment (Saggers & Gray, 1998, p. 185). Although the Saggers & Gray (1998) study was focused on indigenous alcohol problems in Australia, New Zealand, and Canada, their work overlaps with alcohol concerns from an Alaska

Native perspective. Treatment programs designed for indigenous people need to "incorporate indigenous understandings of history, society, and culture [such as] acknowledgement of indigenous and colonial histories, of indigenous social organization and activities, and of continuing language and cultural traditions" (p. 186). This perspective supports the Alaska Federation of Natives report (1989) and the Alaska Natives Commission Final Report (1994) where respect for Native ways of healing alcohol problems in Alaska Native communities is understood and promoted.

Over the past 30 years, many American Native/Alaska Native researchers and authors have written about native ways of healing, which has begun to form a North American indigenous spiritual base of understanding to be used in alcohol abuse recovery (Brant, 1999; Champagne, 1999; Coggins, 1990; Deloria, 1994; Kawagley, 1995; May & Rodberg, 1998; Medicine, 2001; Mohatt & Eagle Elk, 2000; Rain, 1988; Segal et al., 1999; Sun Bear et al., 1992; Thin Elk, 1993; Vick, Smith, & Iron Rope Herrera, 1998; Wallis, 2002; White Bison, 2000). An American Native/Alaska Native spiritual viewpoint tends to centralize a person as part of the natural world in that "we are part of nature, not a transcendent species with no responsibility to the natural world" (Deloria, 1994). Vick et al. (1998) suggest through their exploration of alternate healing methods that the traditional values of Native Americans "hold their land and community as having the highest possible meaning" (p. 10). The cardinal points of reference (East, West, North, and South) are "sacred quadrants . . . . containing special meanings, elements of power, spirits, and sacred teachings" (p. 10). American Native recovery in regard to alcohol dependence and/or abuse involves the mending of "the broken circle . . . [through

strategies such as]: the Sweat Lodge, the Red Road, and the Recovery Medicine Wheel" (p. 11).

White Bison (2002) integrates the 12-steps of A.A. with a "Medicine Wheel"(pp. 61-96) assigning each step in clockwise direction parallel to the cardinal points (e.g., steps 1-3 relate to the powers of the East) (Appendix E). According to White Bison (2002), the focus of traditional Native American lives should centralize the "seven philosophies for Native Americans" (pp. A2-A9), which include a respect for women, children, family, community, earth, creator, and the self (referred to as "myself") (Appendix F). Recently, a commitment to heal alcohol abuse in American Indian/Alaska Native communities was made by Tribal and Indigenous leaders at the "Healing Our Spirit Worldwide Conference Tribal Leader Summit on Alcohol and Substance Abuse" held in Albuquerque, New Mexico on September 3-4, 2002. An excerpt from the summit's official proclamation illustrates a proactive stance toward the use of traditional native ways of healing:

> By being alcohol and substance abuse free, Tribal Leaders will improve the quality of life among American Indian and Alaska Native families and communities. Further, we affirm to enhance cultural preservation, to uphold the dignity and sovereignty of Indian nations, and to support the empowerment of self-determination by focusing leadership attention to dealing with the devastating problem of alcohol and substance abuse in Indian Country. We embrace those teachings of our ancestors as the foundation of our healing. . . . Our goal is to return wholeness to our families and our communities by preventing alcohol and substance abuse in our people,

> treating those who suffer from it, and ensuring that those who have been treated remain clean and sober. We recommend developing Indigenous healing models that strengthen our families and embrace our values, beliefs, and traditions. (Healing Our Spirit Worldwide, 2002)

Native American/Alaska Native communities are increasingly taking responsibility for alcohol and substance abuse by embracing the use of traditional healing methods rather than enforcing Western cultural values in healing.

Summary & Conclusion of Transpersonal Recovery Perspectives

The incorporation of spiritual healing methods in recovery from alcohol dependence/abuse has become increasingly accepted in mainstream therapeutic counseling. A recovery viewpoint in the therapist/client relationship that embraces a person's religious and/or spiritual values tends to foster mutual respect and to draw upon strengths rather than weaknesses. Karasu (1999) suggests the utilization of a "soulful and spiritual" perspective in psychotherapy, which centralizes "six tenets of transcendence" (p. 143): love of others, love of work, love of belonging, belief in the sacred, belief in unity, and belief in transformation. A transpersonal perspective "cultivates depth and sacredness in everyday life" (p. 144) no matter what religious or spiritual affiliation one has chosen. In this regard, tailoring therapy for recovery from alcohol abuse to the person rather than upon a structured therapeutic model allows for the diversity of U.S. society. In addition, people who have no spiritual base can develop a sense of spiritual connection through education and sharing in the therapeutic encounter (e.g., A.A. 12-step program; Recovery Medicine Wheel, etc.). The best possible therapeutic model for

recovery from alcohol and substance abuse seems to be a multi-methodological approach that combines biopsychosocial perspectives as well as spiritual perspectives (Becvar, 1997, 1998; Gregson & Efran, 2002; Lewis et al., 2002; Marlatt, 1994, 1998; Marlatt & Kristeller, 1999; Miller, 1982, 1985, 1986, 1996, 1999; Miller et al., 1998; Miller & C'de Baca, 2001; Thayne, 1997; Van der Walde et al., 2002; Van Wormer, 1995; White Bison, 2002). In this view, a person's beliefs, values, and strengths are used in tandem with practical therapeutic strategies.

CHAPTER II

Methodology

The purpose of this study is to develop an understanding of how women make meaning of the process of ongoing long-term recovery from alcohol dependence and/or abuse in regard to the construction of a *recovered self.* A phenomenological methodological approach was utilized to analyze "capta (conscious experience)" derived from narrative interviews (Lanigan, 1988, p. 5). Thematic data from the autobiographical stories of women who have maintained long-term recovery from alcohol dependence and/or abuse were interpreted and discussed within the theoretical framework of the discursive self (Harré, 1983, 1989; Harré & Gillett, 1994) and narrative construction of self (Gergen, 1991; Gergen & Gergen, 1993). In phenomenological methodology, the narrative interview is one available data gathering method amongst many, which is used for interpretation and analysis of emergent themes from the lived experience of the participants. Phenomenological methodology uses an interpretivist approach based upon the epistemological viewpoint of Constructionism (Crotty, 1998). An interpretivist perspective utilizing narrative interview research method aims to bring to the foreground "the constitutive nature of consciousness and interaction . . . focusing on the ways that the life world . . . every person *takes for granted*—is produced and experienced by *members*" (Denzin & Lincoln, 1998, p. 138). In doing so, narrative researchers strive to construct in-depth understanding of particular phenomena rather than to discover immutable human or social truth. The narrative approach to research differs from other qualitative research strategies such as grounded theory methodology because theory development is not its

main emphasis (p. 160) rather an understanding of shared meaning becomes its central aim

Centralizing A Human Science Perspective

A positivist view toward scientific inquiry represents one end of a continuum in regard to effective ways to conduct research. In contrast, on the other side of the research spectrum is an interpretivist viewpoint, which is indicative of a human science perspective in social inquiry. The positivist perspective has dominated in social science research over the past 100 years or more. Near the close of the twentieth century paradigmatic rhetoric in social inquiry increased regarding the appropriate way to do *valid* research. This epistemological discourse in support of objectivism has attempted to stave off innovative change in research ethic and at times has been defensive, ethnocentric, self-righteous, and thoroughly intersubjectively skewed. The dominant social research perspective that subscribes to only a positivistic view of research has continued to place a so-called postmodern view secondary to and less than the dominant research paradigm. The dominant rhetoric up until the past 25 years approximately has suggested that there is only one way to do research, and that obviously is the social science positivistic way. A social scientific view of social research strives to control, predict, and explain aspects of the human world based upon an epistemology of Objectivism (Crotty, 1998). This perspective seems to be antithesis to how human beings in the real world operate. Human behavior appears to be emergent and contextual in real life not static and easily categorized into nor contained within neat units of predictable reactions under particular circumstances. In this sense, human beings as units of analysis

are very different from the world of natural objects. The study of material objects in the world does seem to operate according to discoverable consistencies compared to the study of human beings, which tends to become a slippery, contradictory endeavor when attempting to seek some semblance of exhaustive explanation.

The scientific argument regarding positivistic views versus anti-positivistic views tends to construct a distinct division between *good science* and *bad science*. The conflict is usually unfairly depicted as an *either/or* viewpoint in regard to the use of quantitative methods versus qualitative methods. A social science researcher is often seen as subscribing to a particular way of doing research or is asked to take a position one way or the other. Bavelas (1995) refers to this dominant perspective as belief in a "false dichotomy" (p. 49). This view tends to continue to perpetrate confusion between methodologies and the use of methods in social research. Crotty (1998) posits that "the distinction between qualitative research and quantitative research occurs at the level of methods" (p. 14) rather than at the epistemological stage or theoretical perspective. Some social science researchers subscribe to a worldview that does not accept or validate any notion of the qualitative methods used in research as being viable choices for research epistemology or methodology. Regardless, objectivism and constructionism sit at opposite ends of a continuum in regard to available research strategies.

Unfortunately, a limited, dominant, scientific discourse in regard to the use of positivism or *doing good science* remains in the minds of researchers who really do know better. I take the position that in order to *do good social/human science*, one must create valid criteria in seeking to answer particular research questions. In this regard, the

context of the research question actually drives the selection of appropriate methodology and methods. The research problem actually "dictates" the selection of effective research methods "rather than the unchallenged superiority of one kind of strategy" (Atkinson, Coffey, & Delamont, 2003, p. 99). Sometimes the effective criteria needed to respond to and best address particular research inquiries are qualitative means rather than quantitative. At other times, a research question may require one or the other strategy or both research strategies to effectively construct an answer. Thus, a postmodern theoretical view of science tends to be a *both/and* approach based upon an epistemological perspective of constructionism.

A both/and viewpoint in regard to social/human science inquiry does not preclude the use of any appropriate scientific methodology or method. A postmodern view of social/human science is often understood to embrace diversity in scientific inquiry and confers respect to all appropriate and effective methodological choices. Consequently, this perspective does tend to render a positivistic vein of thought resulting from a notion of absolute objective truth as an idealistic, unattainable fallacy when studying human beings. Qualitative methods are just as useful in theory-building as are quantitative means. However, quantitative research strategies, which aim toward explanation rather than understanding, often are viewed within the dominant traditional research paradigm as *more* valid. The problem in conceptualizing experimental method as only capable of striving for objective truth is at the root of an epistemological confusion. Yes, it appears that a belief in objectivism leads to positivistic theory, methodology, and methods, which negates an option of constructionist theoretical and methodological research strategies.

In contrast, a constructionist epistemological viewpoint does not preclude the use of experimental method when its use best addresses a particular inquiry. An example of this idea can be understood from the type of research Janet Beavin Bavelas constructs. Her study of nonverbal strategies in communication explores human interaction in regard to the importance and function of facial expression (Bavelas & Chovil, 1997). A qualitative approach in studying questions about how people use facial expression in communicative interaction may not be able to gather appropriate data to analyze. However, a study designed experimentally to observe facial expressions in real interaction can actually ferret out an understanding of how they are used interactively. Of course, this would be in context to a discussion of qualitative concepts such as culture and gender as well, but quantitative strategies could get closer to an in-depth answer in this regard rather than through casual observation, self-reporting questionnaires, or narrative interviews. Even though narrative means for understanding people's lived experience do offer in-depth understanding of particular human beings' situated reality, some aspects of human behavior remain opaque to its participants. No amount of narrative interviewing could capture particular aspects of human behavior such as how in the flow and moment of communicative interaction facial expression is used. We can't observe ourselves as the *other* no matter how skillful or aware we think we are. A belief that any human being can be fully objective in attitude and action seems to be delusional and wishful thinking.

However, a constructionist epistemological perspective may ultimately question objectivism as a valid epistemology, but does not negate the use of critical observation or

experimental methods. Therefore, in this sense, neither experimental research methodology nor experimental methods are entirely the domain of a positivistic viewpoint. They can assist in developing a more comprehensive view of human activity. Both qualitative and quantitative means seem to be necessary to *do good research* depending on the type of research inquiry posed. Not only is a postmodernistic view considered both-and, it also tends to render the conversation about objectivism and constructionism as moot.

Crotty's (1998) discussion of the views of theorists Rue and Milner clearly illustrates a preference for a postmodernistic constructionist perspective of research:

> . . . Rue's presentation of postmodernism [is] an example. Rue describes postmodernism as 'a philosophical orientation that rejects the dominant foundational program of the Western tradition' Rue's study, 1994 (as cited in Crotty, 1998, p. 192). . . . But is he embracing postmodernism or modernism? . . . If Rue's position is postmodernist, it is not merely because it embraces constructionism and anti-foundationalism. What would make Rue's position postmodernist? . . . Milner answers our question by pinpointing an aspect of postmodernism not found in modernism . . . It is the 'progressive deconstruction and dissolution of distinction' lying at the heart of postmodernism' Milner's study, 1992 (as cited in Crotty, 1998, p. 192)

This systematic blurring of distinctions is the hallmark and strength of a postmodern viewpoint. In the art of persuasion, one of the criteria for faulty reasoning is the use of an either-this-or-that type of thinking. It would seem logical to extend this type of

evaluating criteria for critical thinking to form a position regarding effective science. A postmodernist view in contrast utilizes the premise that rigid categorization of scientific perspectives can lead to limited and artificial understandings. Therefore, by removing identification toward false and misleading distinctions in terms of what correctly constitutes scientific investigation, a social/human science researcher can ultimately select from a full range of methodologies and methods to more accurately study the complexity of human experience.

A research question tends to drive the choice of methodology and methods. As a result of my own research inquiry into women in recovery from alcohol dependence and/or abuse, the use of qualitative strategies seem to be the best choice of methods for an effective exploration of the topic. In this regard, lived experience in recovery can be understood from the viewpoint of particular women who have traveled through the process. The authentic stories of women in recovery from alcohol dependence and/or abuse can provide an in-depth view of this courageous and often painful lived experience for those of us who have only observed this phenomenon secondhand or from the outside. Each woman co-constructs her recovery from her own inner resources and awareness along with those of others. In honor of the unique quality of each woman's recovery process, my study focuses on how recovery is personally constructed and lived out in the real life of the women participants. Therefore, constructionism forms the epistemological basis for a phenomenological exploration of recovery from alcohol

Constructionism: Its Related Underpinnings in Phenomenology

Crotty (1998) suggests that there is a linear path from a particular epistemological stance to the choice of methods used in research. For example, the epistemological view of constructionism informs the theoretical perspective of interpretivism; Interpretivism, thereby, informs the methodological viewpoint of phenomenological research; And finally, phenomenological research methodology informs the methods of interviewing, narrative, data reduction, and theme identification (Crotty, 1998, pp. 4-9; van Manen, 1990). The rationale for the use of a specific methodology, therefore, can be traced back to its underlying epistemological viewpoint.

A social constructionist perspective, according to Crotty (1998), claims "meaning is not discovered but constructed" (p. 42). Crotty (1998) explicates concepts of constructionism through a discussion of the:

> phenomenological concept of intentionality . . . meanings are constructed by human beings as they engage with the world they are interpreting. . . . objects in the world . . . may be pregnant with potential meaning, but actual meaning emerges only when consciousness engages with them. . . . All knowledge, and therefore all meaningful reality as such, is contingent upon human practices, being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context. (pp. 42-43)

Husserl's notion of intentionality underlies Crotty's ideas regarding constructionism in that to understand individual human experiences as what they actually are is to see them "only in virtue of their relation to other actual and possible spatial and temporal

experiences" (Keller, 1999, p. 60). In this sense, Husserl posits ideas about human intentionality that point to the qualities of temporality, referentiality, and horizonality (sense impressions) in regard to a person's conscious experiences (p. 60). Husserl's views on intentionality and human meaning led to his eventual construction of the philosophical concept referred to as phenomenological reduction. According to Keller (1999), phenomenological reductionism is the process of "abstracting from whatever presuppositions . . . we may have in the objects of our experiences and reflecting on the contents of our experiences purely insofar as they present themselves to ourselves in consciousness" (p. 61). Consequently, Crotty (1998) refers to intentionality in human consciousness as:

> referentiality, relatedness, directedness, and *aboutness* [italics added] . . . Human being means being-in-the-world. In existentialist terms, intentionality is a radical interdependence of subject and world. Because of the essential relationship that human experience bears to its object, no object can be adequately described in isolation from the conscious being experiencing it, nor can any experience be adequately described in isolation from its object. Experiences do not constitute a sphere of subjective reality separate from, and in contrast to, the objective realm of the external world . . . To embrace the notion of intentionality is to reject objectivism. Equally, it is to reject subjectivism. What intentionality brings to the fore is interaction between subject and object. The image evoked is that of humans engaging with their human world. It is in and out of this interplay that meaning is born. (pp. 44-45).

The notion that people construe meaning interactively in a social environment suggests that human realities are thereby constructed through intersubjective means.

Intersubjectivity: The Social Nature of Human Knowledge Co-Construction

Berger and Luckmann (1967), refer to "society as subjective reality" in the sense that a person "externalizes his [sic] own being into the social world and internalizes it as an objective reality" (p. 129). The authors delineate their ideas further by suggesting that socialization is an "ongoing dialectical process composed of three moments of externalization, objectivation, and internalization" (p. 129). According to Berger and Luckmann, people develop membership in a specific society by becoming immersed in this social dialectic, which begins with the process of internalization. The notion of internalization involves a person's "apprehension and interpretation of an objective event as expressing meaning" [so that] another's subjective processes . . . become subjectively meaningful" (p. 129). Berger and Luckmann posit the notion that a person "takes over the world in which others already live" (p. 130) transforming their subjective world into his or her own reality. The concept of intersubjectivity as it relates to the social construction of reality is clarified by the idea that we, as social others:

> . . . share time in a more than ephemeral way and a comprehensive perspective, which links sequences of situations together intersubjectively. We now not only understand each other's definitions of shared situations, we define them reciprocally. A nexus of motivations is established between us and extends into the future. Most importantly, there is now an ongoing mutual identification

> between us. We not only live in the same world, we participate in each other's being. (p. 130)

Thus, it seems that our knowledge of the objective world of material objects and social others is constructed at the intersections between our internalization and externalization of interpreted reality—always through the vehicle of intersubjectivity. This emergent interpretive process often goes unnoticed by us in similar fashion as we experience the autonomic functioning of our bodily organs. We rarely notice how our bodies are functioning from moment to moment unless there is a problem that captures our attention. We tend not to realize most of the time that we are *ever-interpreting* our personal realities as each moment of our existential experience collides with the outer world of events and people. But, that is exactly what is going on in our "now." Our knowledge of the human world occurs in a context of sociocultural interaction, which centralizes the primacy of human communicative practices in regard to meaning construction.

Schutz and Luckmann (1973) explicate ideas on the social nature of human knowledge production in their co-authored work, *The Structures of the Life-World*, wherein they state:

> The fact that the everyday life-world is not a private, but rather an intersubjective and thereby a social reality, has a series of extremely important consequences for the constitution and structure of the subjective stock of knowledge. . . . From the beginning, the subjective structures of relevance are developed in situations that are intersubjective, or at least they are mediately put into socially determinate meaning-contexts. (pp. 243-244)

Semin (1990) supports an intersubjective view of human knowledge generation by discussing its constitution in "ordinary language . . . a medium that generalizes over . . . specific instances, and over different persons in time and space . . . referred to as intersubjectivity and is integrally linked to social interaction" (p. 160). The understanding that all human knowledge is essentially built upon eons of culturally imbued intersubjectivity appears to obviate any notion of objective truth. Instead, in a postmodern vein of thought, we have multiple ephemeral truths that are culturally contrived and specific.

Gergen (2001) explicates ideas regarding knowledge production as a social process in a discussion about changes in the nature of truth in the discipline of psychology:

> . . . the significant argument is that it is through social negotiation that investigators determine the grounding assumptions (ontology, epistemology) within which research will occur. Once the grounding assumptions (paradigms) have gained consensus, then all interpretations of evidence will necessarily serve as support; paradigms are not thus 'tested' against fact, rather they determine what will be counted as fact. . . . Unmasking the social processes intrinsic to the production of truth also serves to challenge longstanding boundaries . . . (p. 29)

Sokolowski (2000) reiterates these ideas in regard to scientific investigation in that "the move made by phenomenology, then, is to show that the exact sciences are derivative upon the lived world and the things in it . . . it also reminds us that even science is *owned* [italics added] or achieved by somebody" (p. 148). To the social constructionist, truth

cannot be absolute because "data can never prove a theory true or false; whatever counts as data, and how it is credited, requires an interpretive forestructure" (Gergen, 1999, p. 93). An orientation toward centralizing intersubjectivity and interpretation within human communicative interaction appears to be very well grounded within the epistemological perspective of constructionism.

The notion that people operate in a sociocultural world as ever-changing interpreting beings whose interactions are intersubjective and contextually emergent precludes any idea that we can discover immutable laws of human behavior. As a result, responsible human science researchers tend to focus on the development of effective methods to explore in-depth understandings of specific (idiographic) sociocultural phenomena rather than comprehensive (nomothetic) unchanging explanations. Crotty (1998) reinforces this perspective in his discussion of Dilthey's ideas regarding the contrast between *Verstehen* (understanding) and Erklären (explanation), because "he proposes that natural reality and social reality are in themselves different kinds of reality and their investigation therefore requires different methods" (p. 67). Human phenomena occur intersubjectively through co-constructive means and as such are so complex that no simple generalized explanation can capture their essential culturally emergent, unique nature. Consequently, human science researchers employ critical observation and in-depth interviewing to accomplish detailed descriptions and phenomenological understandings of people in particular sociocultural contexts. Additionally, these interpretive understandings are worthy of scientific and social merit.

A Phenomenological Methodology: Narrative Interview Method

The goal of qualitative phenomenological research is to construct an interpretive, contextual understanding of particular human realities. A phenomenological researcher strives for an accurate representation of people's authentic lived experience regarding a specific context. This representation can be accomplished through soliciting personal stories of shared experience. However, a true representation of a particular lived experience may never be fully possible. Crotty (1998) suggests that there is "a certain relativism" (p. 64) involved in representing so-called human realities because in doing so there will always be an interpretive framework. He explicates this notion eloquently by stating:

> What is said to be the 'way things are' is really just 'the sense we make of them'. Once this standpoint is embraced, we will obviously hold our understandings much more lightly and tentatively and far less dogmatically, seeing them as historically and culturally effected interpretations rather than eternal truths . . . (p. 64)

He continues in his discussion to say human realities are "separate realities" (p. 64) and people use "divergent interpretations of the same phenomena" (p. 64) to construct their known worlds. The classic Japanese film *Roshomon (*Kurosawa1950) is an effective example of how multiple interpretations of the same event, recounted by each participant, tend to be skewed through the perceptive filtering process of the person experiencing the event. We tend to see and hear what we want to see and hear or what our previous experiences have prepared us to know. Our filtering systems in regard to interpreting the

outside world of events and people are often underscored by personal interest and bias. In this regard, the method of narrative interviewing, one of the strategies phenomenological researchers use to construct detailed descriptions of lived experience, gathers data from people's personal stories to be thereby represented within an authentically descriptive (narrative interview capta) and a consciously declarative, interpretive framework (narrative analysis).

In regard to phenomenological methodology, narrative methodology, and interview methods, responsible human science researchers are aware of and acknowledge their own biases and opinions when interpreting other's stories. Another way of stating this idea is to reinforce the concept that all human knowledge has been built upon interpretations in a sociocultural environment made in intersubjectivity. In order to represent another's reality in a phenomenological manner is to "bracket" (Crotty, 1998, p. 79) our own understandings as much as possible. Crotty (1998) refers to this process of bracketing, in a phenomenological sense, as a way of:

> "saying, 'No!' to the meaning system bequeathed to us. It is about setting that meaning system aside. Far from inviting us to explore our everyday meanings as they stand, it calls upon us to put them in abeyance and open ourselves to the phenomena in their stark immediacy to see what emerges for us. . . . In describing what comes into view within immediate experience (or even thinking about what comes into view), we necessarily draw on language, on culture. For that reason, we end, not with a presuppositionless description of phenomena, but with a reinterpretation. It will be as much a construction as the sense we have laid aside,

> but as reinterpretation—as new meaning, or fuller meaning, or renewed meaning—it is precisely what we as phenomenologists are after. To take a fresh look at phenomena is, of course, to call into question the current meanings we attribute to phenomena. Phenomenology . . . calls into question what is taken for granted. It is critique and grounds a critical methodology. (p. 82)

The notion of bracketing is attributed to Husserl in regard to his ideas about "*phenomenological epoché* or *suspension of the natural attitude* . . . this bracketing meant that all scientific, philosophical, cultural, and everyday assumptions had to be put aside—not so much to be negated as to be put out of court . . ." (Moran, 2000, p. 11). Thus, phenomenological methodology has a rigorous and systematic quality of researcher *ultra-consciousness*. In this sense, the researcher is not only keenly aware of his or her own voice and worldview, but may choose to include or set them aside during analytic interpretative representation.

In narrative research, the depth or conversational interview becomes an emergent construction site of lived meaning for all parties involved in conversation. Narrative interview method solicits stories from people's lived experience and represents those stories in their original voices. A continuous dialogue of new, constructed meaning takes place in the interview regardless of bracketing efforts of the researcher. Nevertheless, great effort is spent during the interview process in developing an understanding of people's authentic cultural experiences. The notion that narrative interview method is based upon mundane forms of data gathering speaks to the inquisitive nature of people:

> conversation is a basic mode of human interaction. Human beings talk with each other—they interact, pose questions, and answer questions. Through conversations we get to know other people, get to learn about their experiences, feelings, and hopes and the world they live in. There are multiple forms of conversations—in everyday life, in literature, and in the professions. Everyday conversations may range from chat and small talk, through exchanges of news, disputes, or formal negotiations, to deep personal interchanges . . . the research interview is based on the conversations of daily life and is a professional conversation. (Kvale, 1996, p. 5)

Denzin and Lincoln (1994) in their work on qualitative methodologies support Kvale's understanding of narrative interview research methods by positing three criteria for effective data collection: (a) "capturing the individual's point of view," (b) "examining the constraints of everyday life," and (c) "securing rich descriptions" (pp. 5-6). Polkinghorne's (1988), ideas regarding narrative interviewing and thematic reduction reinforce other qualitative researchers' notions of coherence within narrative strategies because "people strive to organize their temporal experience into meaningful wholes and to use the narrative form as a pattern for uniting the events of their lives into unfolding themes" (p. 163). However, these so-called meaningful wholes "rely upon the subjective verbal and written expressions of meaning given by the individuals studied, these expressions being windows into the inner life" (Denzin & Lincoln, 1998, p. 25) of the interview co-researcher. Accordingly, Denzin and Lincoln (1998) posit that poststructuralists and postmodernists suggest there is:

> . . . no clear window into the inner life of an individual. Any gaze is always filtered through the lenses of language, gender, social class, race, and ethnicity. There are no objective observations, only observations socially situated in the worlds of the observer and the observed. Subjects . . . are seldom able to give full explanations of their actions or intentions; all they can offer are accounts, or stories, about what they did and why. No single method can grasp the subtle variations in ongoing human experience. (p. 25)

The interviewer, therefore, from a qualitative research perspective, acts as a guide or navigator during the process of the interview, consciously and purposefully attending to all aspects of the conversational interaction (Kvale, 1996, p. 108).

The notion of craftsmanship frames narrative interviewing as an actual "craft" (Kvale, 1996, p. 105). Kvale also utilizes the metaphors of the "traveler" and the "miner" (p. 4) to describe other aspects of the effective interview researcher. Likewise, Lindlof & Taylor (2002) use a "digging tool" metaphor to characterize effective narrative interview method (p. 183). Additionally, an interview tends to be more effective when the interviewer practices "active listening" (p. 193) skills such as:

> silently asking: What am I learning now? What else should I learn? What can I do to help the participants to express themselves? The researcher theorizes about the possible meanings in what the person said or what the person might have meant. These ideas might be urgent enough for the researcher to gently break in with a question. Just the fact that a question is posed at this point in time tells the participant that the researcher is listening. These moments propel the discussion

> into exciting areas and promote a closer collaboration between researcher and participant. (p. 193)

Similarly, a collaborative perspective on research methods suggests that the interviewer and interviewee are co-researchers.

Research interviewing from a qualitative perspective suggests that the interviewer utilizes interactive strategies that allow interviewees the freedom to answer as they choose. According to Reinharz (1992), the relaxed atmosphere of "open-ended interview research produces nonstandardized information that allows researchers to make full use of differences among people" (p. 18-19). Additionally, a narrative interviewer purposefully traverses through the unknown world of the interviewee by asking probing questions to obtain more detailed responses (Kvale, 1996, p. 133).

Lindlof & Taylor (2002) discuss the use of phenomenology as a "philosophical method [sic] for unpacking the essence of lived experience" (p. 237). They suggest that a phenomenological methodology is composed of three strategies: (a) "Description: the discovery of 'signification systems in the lived reality of everyday life' . . . (b) Definition: 'the reduction of the description to systematic knowledge' . . . (c) Interpretation: a reflection on the previous two phases to 'specify the logic and value that unite description and definition' in order to locate the 'value of social existence,' Peterson's 1987 study (as cited in Lindlof & Taylor, 2002, p. 237). A research strategy of conversational narrative interviewing based upon phenomenological methodology represents a systematic and rigorous application of scientific inquiry. Consequently, qualitative researchers such as Atkinson, Coffey, and Delamont (2003) argue that "we must not assume that what is

done should enjoy primacy over what is said . . . therefore observation and interviewing stand in opposition to one another . . . accounts—including those derived from interviewing— are also social actions" (pp. 97-98) worthy of scientific investigation.

Definitions & Parameters of Study

The purpose of this study is to explore the process of self-identity reconstruction in women living in Alaska who have recovered from long-term alcohol dependence and/or abuse. The key concepts for this research study need to be clearly defined to avoid any ambiguity or misunderstanding in their usage such as what is meant by alcohol dependence versus alcohol abuse or what is meant by long-term recovery. The following discussion of definitions clarifies specific concepts used throughout this study.

Conceptualizations of alcohol and drinking have changed over the years since the advent of seminal works on alcohol such as *The Disease Concept of Alcoholism* by Jellinek (1963), *Drunken Comportment* by MacAndrew & Edgerton (1969), and the popular "Big Book" of Alcoholics Anonymous (A.A.) (1939,1955,1976) among many others. In fact, current usage of the term *alcoholism* [sic] has been replaced by specific reference to *alcohol dependence and/or abuse* or to *substance dependence and/or abuse* in general. Currently, a clear distinction is drawn between the "*use* of a drug that modifies mood or behavior" (p. 4) and the *abuse* of that substance. Additionally, the concept of abuse is clearly differentiated from the notion of addiction. Addiction to or *dependence* on a substance such as alcohol is defined as "when physical symptoms of withdrawal or tolerance to the substance are present" (p. 4). According to Lewis, Dana, & Blevins (2002), the term substance abuse includes "a client's use of alcohol or another

mood-altering drug, [which] has undesired effects on his or her life and on the lives of others" (p. 4). As a result of changes in theoretical perspectives within the substance abuse counseling paradigm, popular usage of the term, alcoholism [sic], appears to have become anachronistic. Although academic and professional ideas have changed regarding substance use and abuse, many governmental agencies and treatment programs in the private sector still use alcoholism [sic] in their titles. This factor tends to perpetuate public understandings of alcohol dependence and/or abuse as a disease. There remains much tension in the substance abuse field and the treatment of alcohol problems regarding conceptualizing alcohol addiction (dependence) and alcohol abuse within the context of the "disease model" (Jellinek, 1963) versus acknowledging the embedded sociocultural factors involved in people's use of alcohol. For the purposes of this study, references to the actual usage of the term, alcoholism [sic], are noted as inappropriate and outdated. Therefore, the phrase, *alcohol dependence and/or abuse*, is used throughout this study to refer specifically to alcohol addiction and alcohol problems.

Secondly, what does the concept of long-term recovery really mean? There are differing opinions in regard to what constitutes long-term recovery versus short-term recovery. The current trend in substance abuse counseling is to conceptualize recovery as a process where the person moves through differing stages of awareness and development in regard to his or her former alcohol dependence and/or abuse. Therefore, an ambiguous use of the term "long-term" exists. Some substance abuse counselors define long-term as a few years compared to others who define long-term as 10 years or longer (Lewis, Dana, & Blevins, 2002; Van Wormer, 1995). Chiauzzi defines the length of time involved in

long-term maintenance of recovery from substance abuse as approximately seven years or longer (Chiauzzi, 1991). The research literature regarding alcohol and substance abuse indicates a 50-60 percent recidivism rate within the first three months of treatment for people who suffer from chronic alcohol and substance abuse (Chiauzzi, 1991, Van Wormer, 1995, Lewis, Dana, & Blevins, 2002). According to Chiauzzi (1989), individuals who are more likely to relapse do so "because of a combination of biological, psychological and social weak spots that lead to distinct and destructive patterns of thought and behavior. . . . [achieving] periods of abstinence [that] range between three months and seven years" (p. 18). Success rates tend to strengthen around five to seven years of ongoing recovery from alcohol dependence and abuse. Therefore, long-term recovery from alcohol dependence and/or abuse is defined as at least five or more years of recovery from alcohol problems for the purposes of this study.

Another ambiguous meaning in regard to recovery from alcohol dependence and/or abuse is the concept of sobriety. What is meant when a person describes their lifestyle as sober? An underlying assumption in the substance abuse field is an understanding regarding the use of the term sober, which equates sobriety to abstinence from the substance. Not all people actually mean total abstinence of the substance (e.g., alcohol) when referring to their sobriety. In the organization A.A., the use of the word sobriety does mean total abstinence from alcohol (A.A., 1976). But, when the terms sober or sobriety are used out of context to A.A. they are often used to suggest a moderate or sparing use of alcohol and/or a person's exercise of self-control and reason in his or her mundane activities. As a result of the apparent ambiguity in the use of the

terms *sober* and *sobriety*, their use in this study has been referenced in context to a particular speaker's intended meaning such as the comments from the various co-researchers' narrative interviews. The term *abstinence* has been used in parenthesis after the use of sober or sobriety when the intended meaning for refers to total abstinence from the substance. However, when a person's intended meaning for sober or sobriety means moderate use of a substance (alcohol) and/or the exercise of self-control and reason regarding the substance, the terms moderation/self-control have been placed in parenthesis.

In addition, the use of the term *recovery* can be understood as meaning a person's return to health. In this study, recovery refers directly to a process of healing and healthy living free from alcohol and substance dependence and/or abuse. A notion of recovery as referring only to abstinence from alcohol is not an appropriate viewpoint for the intended meaning of recovery in this study. It is important to distinguish the intended meaning of recovery in this study from its popular use in A.A. When a member of A.A. refers to his or her ongoing recovery from alcohol addiction and alcohol problems (abuse), the intended meaning of recovery is synonymous with continuous abstinence from alcohol (A.A., 1976). The view of recovery in this study specifically distinguishes the *use* of alcohol from the *abuse* of alcohol. Therefore, the use of the term recovery in this study refers directly to a person's process of returning to a healthy lifestyle, which is free from substance (alcohol) dependence and/or abuse.

A final consideration in regard to definitions of terms relates to the concept of Alaskan women as the research subjects in this particular study. The phrase, Alaskan

women, refers to women who were living in the State of Alaska at the time of the interview. Although the study is about women in Alaska, it does not make a distinction regarding where a woman may have suffered from alcohol dependence and/or abuse or where she may have entered the recovery process. U.S. society is a mobile society where populations are shifting constantly. Therefore, the research criteria used to explore women living in Alaska who have maintained long-term recovery from alcohol dependence and/or abuse was purposefully allowed to be a loose definition.

Co-Researcher Interviews

Adult women living in Alaska who have maintained recovery from alcohol dependence and/or abuse were the co-researchers selected for this study. All participants had at least 5 years of continuous maintenance in recovery from alcohol problems. Nine women were interviewed in this study. Kvale (1996) asserts that "the number of subjects necessary depends on a study's purpose . . . in current interview studies, the number of interviews tend to be around 15 $\pm$ 10" (p. 102). Convenience selection was used to select the nine co-researchers since word of mouth seemed to work best when dealing with the sensitive nature of alcohol dependence and/or abuse. I attended three local A.A. meetings and spoke to the meeting secretary about my research need for women volunteers. I received more than enough calls from women in A.A. Many of the women who volunteered initially did not fit the profile for the study. I contacted four other women through word of mouth referrals. Several women contacted me when they realized the nature of my study.

I had initially proposed to interview twelve women regarding their long-term recovery from alcohol dependence and/or abuse. In between the process of conducting the interviews and the follow-up interviews two of the co-researchers selected for this study returned to practicing alcohol dependence and/or abuse. Their behavior with alcohol disqualified their participation in the long-term maintenance aspect of my research. A third woman was disqualified from participation during the initial interview process when she disclosed her substance abuse problem was not with alcohol, but solely with marijuana and cocaine abuse. I ended up with nine very useful and in-depth interviews with women who have maintained successful long-term recovery from alcohol dependence and/or abuse.

Two Alaska Native women were purposefully selected for interviews in order to provide a range of cultural differences and strategies used in the recovery process of Alaskan women. The co-researchers' interviews were audio-taped for later transcription and analysis. All co-researchers read and signed an informed consent form (Appendix A) describing the nature of the research. The co-researchers were assigned pseudonyms in the research analysis in order to be in compliance with ethical research standards of anonymity and confidentiality. At the time of the first interview, a reference listing of alcohol and recovery related Internet websites (Appendix B) as well as a listing of alcohol dependence and/or abuse prevention and treatment programs for the State of Alaska (Appendix C) were provided for all co-researchers as a resource.

A conversational approach to narrative interviewing was utilized in the co-researchers' interviews utilizing open-ended questions in order to facilitate a relaxed

research environment free enough for the co-researchers to answer with their own stories of lived experience of recovery. According to Kvale (1996), a research interview is "an interpersonal situation, a conversation . . . [where the] interview follows an unwritten script" (p. 125). A schedule of questions was not used as a format structure for the interviews, only general open-ended questions were posed regarding the co-researchers' narratives of recovery from alcohol dependence and/or abuse. In narrative interview research, a co-researcher's authentic story of lived experience is of central concern—told in his or her own thoughts, feelings, and words.

I used a mini audio-cassette tape recorder to record the interviews. The duration of each interview ranged from 45 minutes to 90 minutes depending on when each co-researcher finished her story and after I had asked any emergent questions occurring within the context of the interview. I did come into each interview with a list of demographic questions I wanted answered such as age, race and ethnicity, sexual orientation, family of origin and alcohol behavior, education, vocational background, and geographical location of childhood and subsequent relocation to Alaska. However, in the reporting of this solicited information from each co-researcher, I adhered to issues of confidentiality and anonymity by generalizing locations and jobs. Several of the co-researchers voiced concerns for their anonymity. I assured them that the utmost care would be used in the report of their stories so as not to break their confidentiality or anonymity (refer to informed consent form, Appendix A).

During the process of each interview, I took notes as well as asked questions for the purpose of obtaining feedback and for clarification of certain points brought out in the

stories. I also made notes of specific nonverbal communication such as long pauses and sighs, tone and inflection of words, facial expressions, animated gesturing, and self-reflexive laughter. The reason for noting these aspects of nonverbal communication was to ascertain interpretive understanding from the co-researchers regarding sarcasm, humor, distress, painful memories, embarrassment, emotional upset, and tension of remembering a possible troubled past. I indicated the nonverbal communication in the transcriptions and when appropriate I added these contextual nonverbal messages in the report of the narratives to add nuance of meaning.

The follow-up interviews were conducted several months after the initial interviews. They were held in person when convenient or over the telephone. In addition, several of the co-researchers corresponded with me via email after the initial interview since they had access to my email address and were instructed to contact me or my dissertation chair if they had any questions or comments about the study.

I began the transcribing process as soon after each interview as possible. During this research project I was attending post-graduate courses and was working as a teaching assistant teaching often as many as two undergraduate courses per semester. I had to work my research time around my other work and school activities, which often made it difficult to schedule interview meetings for mutual convenience. I had to schedule two of the interviews as telephone interviews because of time and/or distance problems with meeting in person. A face-to-face interview is desirable because of the richness of nuance in nonverbal communication, but there are nonverbal aspects to telephone

conversations as well such as long sighs, pauses, tone, inflection, sarcasm, and laughter. These aspects were noted in the transcriptions as well.

The transcriptions were typed using the pseudonym for the name rather than the identity of the co-researcher. This procedure is another aspect of confidentiality and anonymity. The nine interviews were conducted over a nine-month period. The transcription process for each co-researcher took approximately four hours per every one-hour of recorded conversation. I did not use a transcription machine or hire another person to transcribe, but could have chosen to do so. Instead I chose to type my own transcriptions of the interviews because I could saturate myself in the actual interview during the transcription process. Through this process of saturation with the narrative interview capta during transcription, I made additional researcher notes not captured during the actual interview. I completed transcribing all of the nine interviews before I began a process of final narrative analysis. The recorded tapes of the co-researcher interviews were kept for reference during the research process and are to be destroyed when the research process and report are completed. Several of the co-researchers for this study were concerned about the tape recordings revealing their identity. I reassured them the tapes would be destroyed after the research was completed.

Methods of Analysis

Researcher interview notes and the transcriptions of the co-researcher's audio-taped narrative interviews provided the data for the narrative analytical process of interpretation. A narrative analysis requires that the researcher use systematic and rigorous interpretive strategies on emergent themes from the transcripted narrative

interview data for analytic discussion. It is important to differentiate narrative interview research and narrative analysis from ethnographic forms of research. Narrative interviews and narrative analysis involve conversations between researcher and co-researchers. Similar to narrative interview research, ethnography involves "a strong emphasis on exploring the nature of particular social phenomena . . . works primarily with 'unstructured' data . . . investigates a small number of cases, . . . and involves explicit interpretation of the meanings and functions of human actions . . ." (Denzin & Lincoln, 1998, pp. 110-111), however, its underlying method of participant observation differs from the conversational interview method of narrative interviewing. In narrative interview method, the research report is a two-fold process: (a) the co-researchers' authentic stories, told in their own voices, and (b) an interpretation and analysis of the stories told, retold in the voice of the researcher. Kvale (1996) posits that the researcher must "reconstruct the original story . . . into a story [he or she] wants to tell" (p. 185) to a particular audience. Lindlof (1995) supports this view of reporting on narrative and the narrative analysis by suggesting:

> the notion that meanings are continually constructed lies at the center of interpretive approaches in communication . . . how we describe the world constitutes what we describe . . . the researcher must decide what kind of author he or she will be, and what sort of story to construct of the facts of the case. (p. 24)

In narrative analysis, interpretation and reinterpretation of emergent thematic data from each narrative autobiography provides a coherent and structured format for discussion

and in-depth understandings of lived experience. According to Kvale (1996), the intent of conversational research interviews is to describe and interpret "themes in the subject's lived world" (p. 187). The narrative analysis, thus, is a:

> form of narration . . . a continuation of the story told by the interviewee . . . a narrative analysis of what was said leads to a new story to be told, a story developing the themes of the original interview. The analysis may also be a condensation or a reconstruction of the many tales told by different subjects into a richer, more condensed and coherent story than the scattered stories of the separate interviews. (Kvale, 1996, p. 199)

A researcher functions as an interpreter in conversational, qualitative research who strives for deeper understanding of interpreted meanings. In hermeneutical interpretation, the interpreter derives from texts deeper meanings beyond the actual words to "work out structures and relations of meaning not immediately apparent in the text" (Kvale, 1996, p. 201). Kvale posits six steps of analysis: (a) "the *subjects describe* their lived world during the interview . . . , (b) the *subjects themselves discover* new relationships during the interview . . . , (c) the *interviewer, during the interview, condenses and interprets* the meaning of what the interviewee describes, and *sends* the meaning back [as feedback], (d) *the transcribed interview is interpreted by the interviewer* . . . five main approaches to the analysis of meaning are condensation, categorization, narrative structuring, interpretation, and ad hoc methods, (e) the potential *re-interview* . . . , and (f) extend the continuum of description and interpretation to include *action* . . . (pp. 189-190).

The utilization of this process enables the researcher to faithfully represent the co-researcher's intended meanings, which mirrors van Manen's (1990) notion of lived meaning and lived experience.

A final consideration regarding narrative analytic methods relates to a researchers' ability to apply systematic and rigorous attention to detail in the identification of the thematic data. Themes from the narrative interviews are emergent rather than being imposed upon the data by the researcher. The emergent descriptive information from the individual stories of the co-researchers is interpretively derived and merged into condensed themes for re-interpretation and analysis. The resultant narrative analysis can be considered a distillation of thematic data into cohesive, interpreted understandings of lived experience and lived meaning. The notion of research validation in a postmodern sense enters into the process of effective narrative analysis in that the narrative method is able to accomplish the goals of a particular research inquiry. Kvale's (1996) concept of "craftsmanship" in regard to qualitative research validity suggests that "continually checking, questioning, and theoretically interpreting the findings" increases the validity of the research study. Research validity in narrative interview research is a non-linear sequential process purposefully enacted by the researcher through all seven stages of validation: (a) "thematizing . . ., (b) designing . . ., (c) interviewing . . ., (d) transcribing . . . , (e) analyzing . . ., (f) validating . . ., (g) reporting . . ." (Kvale, 1996, p. 237). According to Kvale (1996), the validation process occurs as "inspection at the end of the production line to quality control throughout the stages of knowledge production" (p. 236). The seven stages of validation in narrative interview research

achieve a quality of *validation concurrency* because "verification is built into the research process with continual checks on the credibility, plausibility, and trustworthiness of findings" (p. 242). Narrative analysis, then, is a rigorous and systematic method informed by a phenomenological methodological approach based on interpretivism, which aims to describe and interpret a person's lived experience.

My method in the narrative analysis of this study involved moving through Kvale's seven stages of validation as a continuous, conscious process. Not only did I saturate myself in the research capta during the transcription phase, at the point of "digging" (Lindlof & Taylor, 2002) and "mining" (Kvale, 1996) for thematic structures from the capta, I made a list gleaned from the actual capta and systematically color-coded the consistencies among the co-researcher's comments with a highlighter. My working copy of co-researchers' narrative interviews ended up looking like a child's art project of rainbows, yet this color-coding served as a crucial step for finding similarities among the interviews. There are computer software programs such as Nud*ist software ® (non-numerical unstructured data indexing searching and theorizing), which finds thematic strings in unstructured data for the researcher. I chose not to use this form of analytical aid because I wanted to go through a process of being immersed in the research capta as an exploratory, emergent primary process rather than as a second-hand process of discovery removed by separation. However, this type of software program for analysis can save time for the researcher and provide in-depth recognition of thematic structures for later analysis.

In the process of analysis of the emergent interpreted thematic structures, I noted similarities of themes forming many sub-themes. In this respect, I was able to distill central thematic concepts into overarching core themes of shared meaning among the co-researchers' stories of recovery. In order to check thematic structures, I read and re-read the interview transcriptions, pondered upon and meditated about the co-researchers' possible meanings, often referring back to the original recordings to double check for nuance of meaning in the nonverbal and verbal aspects of the conversations. I conducted follow-up interviews with all nine co-researchers to check my interpretations with specific information from the interviews. Also, I was able to fill in holes in demographic data that I had neglected to ask or did not write down clearly in my notes. The follow-up interviews also enabled my co-researchers to provide their reactions and thoughts regarding the initial interview process as well as more ideas about recovery from alcohol dependence and/or abuse.

I had conducted a pilot study early in the research process for this study in order to explore health behavior models. Three health behavior models were used to compare co-researchers' changes in attitude and health behavior: (a) Theories of Reasoned Action and Planned Behavior (Ajzen, 1991, 1996, 2001; Ajzen & Fishbein, 1980, 2000; Fishbein & Ajzen, 1975) (Figure 2.1), (b) Transtheoretical Model & Stages of Change Theory (Connors, Donovan, & DiClemente, 2001; DiClemente, 1999a, 1999b; DiClemente & Hughes, 1990; DiClemente & Prochaska, 1998; Prochaska, 1984; Prochaska & DiClemente, 1983; Prochaska, DiClemente, & Norcross, 1992; Prochaska, Norcross, & DiClemente, 2002; Prochaska, Redding, & Evers, 1997) (Figure 2.2), and (c) Social

Cognitive Theory (Bandura, 1986, 1997, 2001) (Figure 2.3). These *a priori* health behavior models are contrasted in the final narrative analysis with a communication model (Richey, 2002, unpublished pilot study) regarding health behavior change I constructed in the process of doing this research.

CHAPTER III

Narrative Interviews

Autobiographical Description, Narrative Co-Construction

A person's life story resonates aspects of self in regard to identity construction as well as deeper psychological themes of personal feelings and unique interpretations of experiences. The telling of a person's autobiographical story or "life story" (Atkinson, 1998) serves many functions such as: (a) a psychological function, (b) a social function, (c) a mystical-religious function, and lastly, (d) a cosmological-philosophical function (pp. 9-10). According to Atkinson (1998), the function of the life story is similar to the use of myths and folktales because they "carry the timeless themes and motifs found in living mythology" (p. 9). We can relate easily to the story form of autobiographical narration. An aptitude for making sense of others through their self-narration is a uniquely human ability. Fisher (1989) aptly refers to us as "homo narans" (p.57), which is an extension of our unique sentient ability and speaks to our storytelling nature as a means of constructing our realities and sharing knowledge. We tend to understand the natural rhythm of narration by expecting to attend to a beginning, middle, and end to a story. We are naturally tuned into the sequential quality of a story's plot line, or what Atkinson (1998) cleverly refers to as the "beginning, muddle, and resolution" (p. 19). The study of a person's life story or of a recounting of a certain era of a person's life satisfies a scholarly aspiration to understand aspects of human experience. Atkinson suggests that we make sense of others' reality through studying the "telling [of] one's life story" (p. 19). He goes on to indicate the study of a life story explores:

> . . . enduring questions of human development: What makes a given transition take place? What is the mature personality like? Is there a directedness to the life course? Is there a unifying theme to the life? How is a sense of continuity maintained in the face of change? (p. 19)

Questions similar to these motivate qualitative researchers to investigate the situated knowledge of people's autobiographical narration for themes—for deeper significance. Gergen (1994a/1999) goes as far as to make a case for the notion that "stories . . . serve as a critical means by which we make ourselves intelligible within the social world" (p. 185). Peoples' narratives of self supply the narrative researcher with idiographic "lived meaning" (van Manen, 1990, p. 183) or lived experience. According to van Manen (1990), the qualitative study of lived meaning attempts to represent "the way that a person experiences and understands his or her world as real and meaningful . . . describing those aspects of a situation as experienced by the person in it" (p. 183). He delineates this notion further by suggesting we are not usually "explicitly aware of these lived meanings" (p. 183) ourselves without deeper conscious reflection. Consequently, a qualitative researcher who studies people's autobiographical narratives systematically strives to construct a descriptive picture and story of these authentically lived experiences as well as critically explores and "mines " (Kvale, 1996, p. 207) for embedded themes in the narrative text for academic interpretation of situated meaning.

Another important aspect of personal narratives is their co-constructed nature in mundane interactions with conversational others. Ochs & Capps (2001) refer to unpolished everyday narratives by people as "living narratives . . . [in that] narrators may

start out with a seamless rendition of events only to have conversational partners poke holes in their stories . . . narratives are shaped and reshaped turn by turn in the course of conversation" (p. 2). The co-constructive quality of people's narrative accounts is often a hidden element in a discussion of meaning from people's lived experience. We rarely think about casual conversations as construction sites of significance in our lived experience. But, that is what occurs in most conversations where people are recounting tales, according to Ochs & Capps (2001), who eloquently state:

> The difference between telling a story *to* another and telling a story *with* another . . . of incidents, especially those that happened recently and those half-forgotten or repressed, often look like rough drafts rather than finished products. Narrators have something to tell, but the details and the perspective are relatively inchoate; they are still in the middle of sorting out an experience. . . . Narrative activity becomes a tool for collaboratively reflecting upon specific situations . . . the content and direction that narrative framings take are contingent upon the narrative input of other interlocutors, who provide, elicit, criticize, refute, and draw inferences from facets of the unfolding account. In these exchanges, narrative becomes an interactional achievement and interlocutors become co-authors. (pp. 2-3)

The research interview is a conversation as well as a process and site of co-constructive meaning between interactants. In this respect, an interviewee who is recounting a segment of his or her lived experience to another can in that process have new understandings of lived experience due in part to the other's comments and feedback.

The recounting of a person's lived experience then can be understood as a dynamic, emergent, interpretive process rather than a set of unchanging events to be retold with no reconstructive meaning.

Another aspect of the narrative interview is the importance of the "positionality" (Davies, 1992; Davies & Harré, 1990) of the speakers, which centralizes co-cultural communication (Orbe, 1998) as a contextualized interpretive layer of meaning-making. In this regard, the researcher and the research subject's position as a speaker must be consciously represented in the description and analysis of lived experience/meaning. In my own research, the research subjects are women and I am a woman researcher, therefore, to assume that we are positionless in our talk denies an essential aspect of authentic lived experience and a necessary layer of lived meaning. A person's story of self must be represented in context to one's "personal history of being positioned in particular ways and of interpreting events through and in terms of familiar story lines, concepts, and images . . ." (p. 57). We all have a position or standpoint regardless of how we choose to represent it in our work and our talk. Therefore, as a socially responsible researcher, my work academically explores the notion of "standpoint" and "relational standpoint" (Hartsock, 1983, 1997a, 1997b; Wood, 1996a, 1996b, 1996c, 2000, 2001), "positioning" (Davies, 1992; Davies & Harré, 1990), "muted groups" (Kramarae, 1981, 1996), and "co-cultural communication (Orbe, 1998) as integral ingredients to the construction of self.

Representation of Co-Researchers' Stories

The following section contains the nine co-researchers' stories regarding recovery from alcohol dependence and/or abuse. A brief description of each co-researcher's demographics and interview setting are included stated in my voice as the researcher prior to the beginning of each co-researcher's story. The co-researchers' narratives are told in their words, thoughts, and opinions in order to be accurate accounts of lived experience with alcohol dependence and/or abuse and their recovery process. Any researcher interpretive comments regarding the nonverbal aspects of each co-researcher's story are placed in parentheses to keep the natural flow of the story.

Maggie's Interview

Maggie lives in South Central Alaska in a small seaside town and is a 47-year-old heterosexual woman. She has resided in Alaska for 13 years after relocating from the U.S. Southwest. Maggie was raised in an alcoholic family. As a counselor, trainer, and coordinator in the alcohol and substance abuse prevention field she works with adolescents and adults. She has had more than nine years of continuous recovery from alcohol dependence/abuse. In addition, Maggie has maintained 17 years of recovery from cocaine abuse and has committed her life to the work and service of prevention from alcohol and substance abuse. Her primary concern is to educate young people, so they can make informed choices regarding their own health behavior.

I first contacted Maggie in the process of compiling research on the various prevention and treatment programs in the State of Alaska. I called her office to talk to someone about the services they provided. Maggie was the person I spoke with

regarding alcohol treatment and maintenance programs. She was very open and willing to discuss her work. In the course of the conversation, she admitted that she was a former alcohol and drug abuser. She volunteered to become a participant for my study regarding women living in Alaska and long-term recovery from alcohol dependence and/or abuse. We agreed on a time to conduct a telephone interview. Maggie's work and my work as a teaching assistant as well as our physical distance being in different towns precluded us from being able to get together for an in-person interview.

Maggie was able to donate an hour of her time to talk to me about her story of recovery. She had the blue ocean and majestic snow-covered mountains of Alaska to view outside her office while I sat in my office with no window. I was surrounded by my research paperwork and had my notebook ready to record notes from our conversation. Maggie's unfolding story spoke of intense troubles with drugs and alcohol lasting for a 26-year period in her life.

Maggie's Story

Maggie says she has resided in Alaska for 13 years after relocating from the U.S. Southwest. She states she was raised in an alcoholic family. She describes herself as the "oldest out of five kids . . . and was the only one . . . affected with alcoholism [sic]." She describes her siblings as "seldom" drinkers, yet one of her brothers was arrested for driving while intoxicated (DWI). I asked her about her racial and ethnic background, she replies she is Caucasian—German, English, and Irish. However, during a follow-up telephone conversation, Maggie mentions her mother might be "part Native American, probably Cherokee." Apparently, according to Maggie she indicates her mother does not

actually know her heritage fully, but there has been "talk" in the family describing her mother and her mother's brother as having a "dark complexion, hair, and eyes."

Maggie says her father never recovered from his alcohol dependence/abuse. As a result, according to Maggie, he died from alcohol dependence and/abuse. She says her mother eventually was able to recover from alcohol abuse due in part to her own success in recovery. Alcohol use and abuse were such pervasive behaviors in her family, according to Maggie, she describes becoming alcohol dependent at a young age, approximately nine or ten years of age. Maggie describes herself as a "dual-diagnosed" person in recovery, which means she has had "emotional and/or mental problems occurring alongside her drug and alcohol dependence/abuse." Maggie says she has spent 26 years of her life being dependent on and abusing alcohol before becoming sober.

Maggie states at the age of 35 she was forced to face her own alcohol dependence/abuse because she had been court ordered to get treatment as a result of being arrested for the third time for driving while intoxicated (DWI). Maggie describes her drinking days as "wild," she says she would "call everybody up . . . I was pretty lively." According to Maggie, "the bar life seemed normal to me." She indicates she even bartended as an occupation for 10 years during her drinking days. Maggie refers to the bar life as:

> "colorful . . . I don't regret a lot of the people I met in my life. When I think back on it, there is a lot I would do different, but it is fairly safe to say that I had a good time without killing myself . . . but I was pretty chronic when I was drinking.

Prior to becoming sober, Maggie says she had been through three treatment programs. Maggie states her first experience with treatment for alcohol dependence/abuse was in a 6-month outpatient program. She describes her experience of attending group therapy once a week while in the treatment process. During her second attempt at treatment, Maggie says she actually committed herself to a 30-day inpatient facility, which was located outside of Alaska in the Pacific Northwest. According to Maggie, she says she has "been incarcerated numerous times for DWIs and . . . life had become unmanageable:

> . . . I was sick and tired of being sick and tired. I got sick and tired of sitting in jail. I got sick and tired of hurting my family, my children, the lying, the deceit—it just caught up with me. I came to realize that all my life were lies and just the full- blown denial hit me right in the face. It was very hard sitting in jail several times . . . if I added up the time—I had done two years in jail. . . . those weren't all at once, but it was enough to devastate my family and my kids . . .it is so hard.

(Maggie took a long pause after recounting this part of her pre-sober days, and I gave her some time to reflect on this before we continued the interview).

Finally, the third time she entered treatment, Maggie recounts she stayed in Alaska, but once again she describes being committed to a 30-day inpatient program. The third phase of treatment, according to Maggie, was her turning point toward a healthy lifestyle. She describes her experience at the end of the 30-day treatment:

> On the day of my release, I asked them if I could stay for another 30 days. They let me stay in a halfway house. And that helped a lot. I actually lived right in the treatment center for that month. They allowed me and one other lady to stay. It's

> not a normal practice . . . we got on our feet and did real well. I stayed sober for three years after that.

Maggie says she relapsed for six months after being sober for those three years, when she describes meeting a man who was a heavy drinker. Prior to getting involved with him, Maggie says she had not had any relationships with men. According to Maggie, it is the policy of most treatment programs for alcohol dependence/abuse as well as in A.A. to recommend to people in recovery to stay away from new romantic attachments for a while. Maggie describes her story of craving closeness, sexual satisfaction, and loving:

> . . . the relationship I was in got me to go back to drinking. . . . I didn't date for three years and I was pretty happy . . . well, I was lonely and I hadn't had sex for a while. And it was . . .all right. . . the next thing I know he was moving in—controlling me all over again and . . . here I am again. (interviewer comment:

Maggie says her co-dependent behavior seemed obvious to her during this sequence of our conversation. (Maggie was very amused with her own comments here and was audibly chuckling to herself.) She describes re-entering her recovery after six months of apparently re-enacting old behavioral patterns. She mentions relapse as a necessary part of recovery within regard to success in making a health behavior change:

> I think the point of readiness is when you give in to all of those [pressures] . . . when you say I can't do this anymore. . . . I have been in recovery for 17 years from cocaine, eight years from alcohol—I would have 12 years but I had a 6-month relapse. . . . I consider relapse a part of recovery. Every time I relapsed I found that I needed something else. It's a point of mental health and a point of

> anger management. There are so many issues . . . that's part of why treatment works [initially] . . . the 30-day period . . . is barely enough to dry yourself out . . . I didn't go into treatment for cocaine, but I went into treatment three times for alcohol. . . . each relapse, it was something different that helped me out . . . a little more in understanding myself because I drank for 26 years. So, people can't expect you to get well in 30 days!

Maggie says her last round of treatment as she became committed to a sober lifestyle involved intensive therapy. She describes having had a very gifted alcohol and drug counselor as her therapist, who had himself previously been a substance abuser. According to Maggie, she says he pushed her "buttons" in therapy. Maggie states her therapist suggested that she learn about anger management. Maggie says her reaction was intense anger:

> He told me that I needed anger management and I got really pissed off! . . . I told him he could go stuff this. I was so stubborn I ended up taking anger management three different times due to my process in treatment . . . then, I turned around and took it twice on my own. It just devastated me—there was something said in [treatment] that woke me up. . . . I ended up being very good friends with that teacher . . .

Maggie remarks about her bumpy road to recovery by suggesting that it was her apparent "stubbornness" that contributed to the depth and length of time it took to become successful in her process toward health. She states, "denial is like cement" at times, but

something life-changing took place in the accumulated treatment episodes that led to her eventual full recovery.

Recovery, according to Maggie, she says is something that she takes very seriously, and works at her recovery every day. Maggie describes The Twelve-Step Program of A.A., as being part of her recovery program since early in her recovery. She says she maintains her sobriety through a combination of practicing A.A. principles, attending regular meetings, and incorporating an ever-maturing sense of spirituality into her daily life. According to Maggie, she stopped going to A.A. meetings and stopped following a spiritual process in regard to her recovery were the times that she "relapsed" into old behavioral patterns. Maggie mentions she has been in a long-term relationship with a person who has been in recovery for 11 years. She refers to this relationship as "a balancing touch that has added to [her] serenity."

Maggie speaks of her chosen profession of prevention and alcohol and substance abuse education and her dedication toward self and service toward others. Even so, according to Maggie, she is extremely aware of the notion that the type of people she used to "hang out" with are the same types she works with in her job. She insists she knows that it is very important for her to create boundaries because she has:

> to be very careful with people like that . . . it's an addictive process [too]. You know, a lot of things we pick up . . . tobacco, men, or booze—anything we do can become a habit . . . that is why people go back to drinking because it is familiar to them more than changing. It's easier to go back to something you are familiar

> with [since] you know the outcome rather than to go into that dark hole and take a chance. . . that's why it keeps going—it's seductive in that sense.

The development of her current job, according to Maggie, took place over a long period of time. She indicates that first she had to get "over" all of her denial before she could work effectively with others. She mentions she did volunteer work in the beginning, which was almost a natural outcome of being in recovery. Later she says she was able to secure work in the substance abuse field where she continues to take care of herself and others.

Maggie states she has specific advice for women who want to make the change toward health and/or who are already in the process of recovery. First, she suggests women could reach out for help and let others help. Maggie thinks often, some women tend to want to be in control and take care of things themselves without assistance from others. Women can change, according to Maggie, "they don't have to keep on doing the same thing." Secondly, she suggests the notion that women tend to stay in the home isolated from others only serves to keep them stuck in their unhealthy patterns. In regard to isolation, Maggie also stresses the idea that many women are "ashamed" of their problems with alcohol and what has happened to them. Maggie indicates they also tend to be frightened of the "unknown:"

> I was thinking about this the other night. It is almost like a cold death eerie feeling to know that you are the only human being down to that level because you hit so low . . . you hit a bottom . . . it's really hard to get . . . into treatment, it's

> scary and frankly . . . they shouldn't call it treatment—they should call it the *road to recovery* or something like that—treatment sounds too scary.

But, for the most part, Maggie says she thinks that recovery is a personal process whether one is a woman or a man. A final concern for those who want to recover and/or maintain their recovery, according to Maggie, is the notion of prevention and the education of young people before they get established into negative patterns of alcohol and substance abuse. Maggie indicates she is dedicated in her prevention work, and tells *it like it is*:

> I share my story . . . to teens and tell them it is not their fault. I try to mentor . . . I had certain mentors in my life and when I look back that really helped me to stay focused on what I needed to do. I hope that helps in a small way . . . it's worth it to me. . . . my oldest kids drop in to say hi and it's nice to see 'em and it's nice to see that they changed—maybe not because of me [alone], but . . . from others [too] . . . I am glad that they feel comfortable enough to stop and say hi.

Every day, according to Maggie, in her own way, she seems to be making a difference in people's lives as it relates to recovery from alcohol and substance abuse. She says she maintains her own recovery by being immersed in the service to others in need.

Beth's Narrative Interview

Beth temporarily lives in the interior of Alaska while attending college, but is originally from the Far North region of the state. She is a 56-year-old heterosexual woman and non-traditional student, who has returned to college to pursue an academic career in psychology. She has maintained approximately 7 years of recovery from alcohol and substance dependence/abuse. At this point in her life, she is dedicated to

learning as much as possible about herself and other people's emotional growth processes. Beth intends to apply her knowledge in a practical way by helping people who are embroiled in alcohol and substance abuse become self-aware and be able to make positive changes in their lives. She may do this by returning to the village where she was raised. At the time of her interview, she has several years of schooling remaining in order to achieve her goal of a college degree.

Beth agreed to become a participant in this research study when she realized that my work was with women in recovery. She wanted to join in so that her story might make a difference for women like herself who had spent years being "stuck" in alcohol and substance dependence/abuse. We mutually set a date for the interview, which was accomplished in person in a private office at school. We spoke for shortly less than an hour about her story of recovery. I sat with her taking notes, but mostly was enthralled with her very charismatic and passionate rendition of personal lived experience with addiction and her profound life changes.

Beth's Story

Beth says she was raised in a village on the Arctic Ocean in the Far North region of Alaska. She describes her racial and ethnic background as Inupiat, which refers to a specific group of people within the more general designator of Alaska Native. Beth says she is very proud of her particular ancestry, location, and heritage (her face lit up as she talked about her culture and people). Beth mentions that she resents being lumped into the umbrella term, Alaska Native. Beth maintains that U.S. society should not generalize about indigenous groups of people in Alaska because there is such difference among the

various groups. According to Beth, people from the "majority" or dominant (Caucasian) group in Alaska, often attach negative stereotypes to their meaning when using the term, Alaska Native. The notion of assumed status differentials between the dominant culture and the Alaska Native cultures, in Beth's opinion, suggests that some majority people tend to think that Alaska Natives are "low-class" people. She offers more information about her ancestry by stating:

> My grandmother is a half-breed, she is half Irish and half Inupiat. She was the only child . . . not raised by her Irish father. Her Inupiat aunt adopted her. She had 15 children, but most of them died. [My] mother is the last living child from my grandmother.

Beth says she was raised in a very strict and religious family—the "hell fire and damnation" type of religious viewpoint. Her parents, according to Beth, were non-drinkers . However, she describes her parents as "verbally abusive" in their treatment of their 11 children. She also mentions that there was "physical abuse too." Beth says she is the fourth oldest child and that she and her 10 siblings all became "alcohol and drug addicts." She believes that her mother may have self-medicated by using prescription drugs as well as hiding this from others in the family.

Beth describes her early adolescent life with her family was severely disrupted when she was required to move 2,000 miles south of her village to attend the 8th grade. She speaks of this time in her life with a very deep sense of pain and sadness:

> We were forced to speak English outside the home. We were really abused in the school system. Things were forced. If we didn't do as we were told we had to

> stand with our arms extended and couldn't put them down for hours. If we were bad we had erasers thrown at us. I know that had a lot to do with how I became rebellious. The 12-year-old kids had to take care of the younger kids—five and six year olds . . . we felt so sorry for them because they would cry all night. In fact, for years it bothered me . . . sometimes I can still hear those little children crying. . . . I look back and, ah man, the hurt . . . they were forced under the showers . . . kids screaming—they had never experienced these things.

Beth says she was also sexually abused when she was eight or nine years old by a neighborhood storeowner. According to Beth, this terrible experience had a "really drastic effect" on her because she continued to feel like "scum" afterwards. The combination of being raised in an abusive home, being forced into a hostile school experience, and being sexually abused were foundational, in Beth's opinion, to her eventual alcohol dependence/abuse. In addition, she says the notion of straddling two cultures made life a very uncertain experience for herself and her siblings. The apparent tensions involved in navigating between the dominant U.S. culture and the Inupiat subsistence whaling culture, according to Beth, was "like living in two worlds . . . I did not live my reality very well, none of us did . . . my whole family became alcoholic and drug abusers." She recounts the story of when she was 18 years old she stood up to her mother's verbal abuse and moved away from home to the Southern part of the U.S. where her sister lived.

Beth says she married a Caucasian man just to "spite her mother," but that this marriage only lasted eight or nine months, however, she became pregnant with her first

child. She says she was divorced and took her baby home to her mother. Her mother tried to take charge of the baby so she describes eventually moving to a larger city in the Interior of Alaska. According to Beth, she married again and had another child at this point. She mentions that she married an alcoholic man. Beth speaks of "really partying" during that period in her life. According to Beth, she says she did not "know much about alcoholics" or about "drinking too much." She recalls the craziness of those days by remembering:

> . . . once I got really angry and I tore up one of his little rubber rafts just out of spite. Ah, I almost forgot that. Why did I do that? Things like that bothered me. But I was drinking a lot then. . . . he was an alcoholic. He was 11 years older than me and oh, what a bad drinker! He used to have martinis all of the time. I think I was 20 or 21 by then and was drinking hard liquor . . . He was British . . . he just drank all of the time and my heart . . . had a lot of restriction around it. I don't think I had any feelings.

After 5 years, Beth says she decided to leave her husband. She recounts how she made plans with her sister to leave him. But, she says the night that she had planned to leave he committed suicide by shooting himself. Beth describes this traumatic sequence in her life:

> The night before I left he shot himself. What a drama. I don't even remember. My mother had to come down. I did go to the police beforehand because he threatened but they couldn't help. I was drinking and he was drinking. I remember he told me he was going to do it if I left and the police didn't believe

> me. I was too young, too naïve to do anything about it . . . that was the most traumatic experience in my life where I didn't have any feeling anymore. He had been sexually abusive to me and fooled around on me a lot. I didn't love him . . . I think I used him to get away from my mom.

Beth speaks of moving to another large city in Alaska where she became deeply involved with church. She mentions studying for two years at a Bible college. During this period she describes being sober for about three years. Then she says she started drinking again. Beth mentions living with her sister who was drinking and smoking marijuana at the time. Then, according to Beth, she met a "Native guy" while working for a Native corporation and fell in love. In her own words, Beth describes this time in her life:

> I was working for a Native corporation and after awhile I met a Native guy. . . . I was searching for my identity . . . I had had it with white guys. He was so handsome. He was so fluent in Inupiat and he was so charming, so funny, and so kind. I was really captivated. . . . I felt a real longing to go home. I couldn't connect with [a large city] anymore. So, I lived like a white person, but inside of me I wanted more—to go hunting and fishing—he captivated my heart. We started fooling around and boy did we drink! . . . many people would try to say to me "watch that guy" . . . I got pregnant again and we went back to his village and it was a big cultural shock to me. There was no phone, no nothing.

Beth says she did not use alcohol when she was pregnant. In fact, she did not drink for the seven years she lived with her husband in his village. She describes her husband as a binge drinker who would just leave and be gone for days. He was abusive toward her,

she mentions, but not the children. Beth left him after he had gone on a lengthy binge leaving her and their children stranded in a strange village. Beth states she "didn't want to live like that . . . I was under too much pressure from physical abuse . . . inside I was devastated." She describes going back home to her village at this point. She indicates she began drinking again when she moved home to her village. Beth speaks of her emotional state at the time due to alcohol-related problems, physical abuse, and emotional abuse:

> . . . devastated . . . I was bleeding inside of me, I was torn up, I was wounded. I was badly damaged. You name it. I was depressed, but nobody knew it. . . . I got a job. I started drinking . . . and partying more than ever. 1982 was my heaviest drinking days. [My husband] drank until the point of not knowing what he was doing. And I was drinking too, but I knew what I was doing . . . the kids were in the house . . . there was emotional abuse. He almost killed me and I went to the hospital . . . I didn't want to press charges but the injuries were so severe they wanted me to, but I said no.

Beth states her husband was court ordered into treatment at this stage of their mutual drinking careers. In 1991, she says her husband quit drinking because he finally realized that he had almost killed her. He quit drinking and quit being physically abusive, according to Beth, but she says she continued to drink and smoke marijuana for another 5 years approximately. She describes herself during this period as:

> . . . deserving it . . . my husband was still abusive emotionally, and I didn't know about the dry drunk. But in 1996, I felt like I couldn't get out of bed. I had six

> children. I felt like I was cornered and just dead. I was really dead inside on the outside I was pretty good with organizing and in my job I put up with a lot of stress. . . . I was tired of my relationship. I wanted to keep it together, but I couldn't see how we could continue living the way we were. He couldn't or wouldn't communicate with me. He was very apathetic. He was diagnosed with chronic mental depression. I didn't know what to do. Somewhere there had to be God out there. Deep inside of me I just cried out.

Beth maintains this was the period in her life when she began her journey toward full recovery from alcohol dependence and abuse. Beth says as she gradually recovered from years of intermittent alcohol and drug abuse, she remembered a reverie or a "vision" she had as a young woman that, according to Beth, symbolized her struggle with "insecurity:"

> . . . there was something in me that was so insecure . . .I remember one time . . . I don't think it was a vision, but I saw myself . . . like a little eaglet way up there . . . and the mother eagle was around somewhere. I was with my eaglet brothers and sisters . . . I was the only one that could not go out there and fly. I could not! That was me . . . I couldn't let go of whatever it was that was holding me. I know now that it was insecurity.

Beth posits she apparently decided to face her insecurities and make changes toward a healthy lifestyle. She says she had spent most of her adult life intermittently abusing alcohol and drugs with long stretches of time being sober. She states she was 49 years old when she made permanent changes in her life.

Beth describes how a friend had loaned her a book on recovery to read while she traveled to Hawaii for a vacation. She recounts how she was greatly affected by the information about alcohol addiction and recovery in the book. Beth says it "was a gift from Heaven . . . that was what I needed to learn" because the author of the book talked about feelings, boundaries, detachment, and letting go. Beth states she realized that she had no boundaries and that her feelings were shut down. The author, according to Beth, also discussed controlling behaviors of people who were really out of control. Beth describes knowing that she was:

> the number one control person trying to always fix things. In fact, I did the most damage to my children by not letting them accept responsibility . . . without fixing it for them. I had to forgive myself big time! We came back from Hawaii and the first thing I did was go to the counseling center.

Directly prior to her revelatory experience with her friend's book, according to Beth, she had gone through a 6-week program to quit smoking. She says she felt as if she couldn't catch her breath and that she was "committing a slow suicide." The counseling center was the same place she says she had gone to for the no smoking program. She describes seeing a therapist and began attending A.A. meetings. Beth says she began to explore all of her childhood issues, her sexual abuse, and the suicide trauma from her young adulthood. She states she realized that she had post-traumatic stress syndrome. Beth describes letting go of her husband by not trying to change him anymore. She states she found out that he was a "dry drunk," who, according to Beth, stopped drinking, but never dealt emotionally with the poor relational behaviors involved with his drinking. Beth

describes realizing now that she "was the only one who could take care of herself." She said her "serenity started to grow and grow" during this period of intensified change.

Beth stresses now that she has maintained her sobriety in recovery for seven years. She says she maintains her recovery by continuing to learn and grow. Her spiritual studies have expanded beyond the Bible, according to Beth, to studying other views and seeking more enlightenment. Beth describes Eastern cultures as such "wise people." Beth says she is keenly interested in the mind-body connection. She admits she is definitely on a journey of "self-discovery." She insists she now listens to her "inner voice."

Beth describes her family as not being much of a support for her in that many of her siblings are still embroiled in alcohol and substance abuse. She says she has had to find her own support system. Beth states that she made new friendships since she had to let go of her "party friends." She asserts school has become a passion for her and that she is committed to obtaining her four-year degree. Beth says she knows that she can do something special for her people with the education. Beth describes attending church often as well as trying to attend A.A. meetings. She admits that she has slacked off in her regular attendance at church and meetings since she has gone back to school. According to Beth, she keeps occupied with learning, "I love it so much . . . I just love psychology and learning about the brain and the mind-body . . . it's so fascinating who wants to go back to that?" Beth says she has grown so much that she now is learning to be able to give back her knowledge in recovery to her home community.

Beth maintains that recovery is a "very personal walk." According to Beth, women tend to be more emotional than men. She says her experience with the women in her family is that the women have "highly expressed emotions." Any advice, then, according to Beth, is to "keep it simple . . . rather than complicating things" so much. Beth suggests that the environmental stresses inherent in her previous lifestyle led her to choose alcohol abuse. So, she recommends learning about oneself and one's relationships—one's boundaries and feelings are important. Also, friendships are important for women, according to Beth, she says that she is "very grateful . . . I can share . . . with my girlfriends." Beth indicates she is part of something greater than herself, which is the Native movement in her home village. She says she has committed her service to helping women in her village to seek treatment for themselves and their children. She describes this idea by stating:

> At the mental health center, oooohhh! Many people wouldn't go to it. And there are so many mothers out there with teenagers that are really suffering. They don't know what to do and I'm trying to help them. Yet, they won't put their foot in there. And I can see why because [the healthcare workers] are so high and mighty. They can't identify with our people and our people didn't identify with them. So, I rolled up my sleeves and I said I'm going back to school. So here I am. Something happened where I just wanted to learn. I don't want to drink and dope anymore.

Beth speaks of returning to her village this next school year to make a difference in her family and her community with her hard earned recovery expertise.

Denise's Narrative Interview

Denise is a 35-year-old heterosexual woman who has lived in the Interior of Alaska since 1996. She lived and worked in Alaska at the time of our interview. She has since moved outside of Alaska to attend a university in the Pacific Northwest to obtain a degree in veterinary medicine. At the time of the interview, Denise had five years of actual sobriety, but approximately "seven years of recovery process." She was raised in New England and moved to the West Coast before relocating to Alaska. Denise described her racial and ethnic background as "mostly German" mixed with Irish Protestant. During a follow-up discussion, she indicated that she was back in Alaska for the summer to work before going back to school in the Fall. She was thrilled to finally be in a position to fully pursue her dreams. Denise met me for her interview in a private office at the university. There was a majestic view outside the window of part of the snow-capped mountains of the Alaska Range, which formed the backdrop to our conversation. Denise volunteered for my research regarding women in Alaska in long-term recovery from alcohol problems after becoming aware of my project. She was very enthusiastic regarding being able to share her story of recovery. Denise is hesitant about pressuring her family to look at their alcoholic behavior. Instead, she insists that, "just because they are inclined to drink doesn't mean they are suppressing as much as I did" while drinking. Other than the "normalized" drinking behavior in her family, Denise said she had a "relatively easy life . . . [and in therapy] couldn't really pinpoint anything really horrible that could be the cause" of her own relationship to alcohol and addiction.

Denise's Story

Denise describes coming from what she refers to as a family of "functioning alcoholics." She says her parents drink regularly in the sense that it is "very easy for [her] parents to polish off a bottle of wine at dinner, have an after dinner drink . . . and none of us appeared drunk." Denise talks about drinking as:

> part of everyday . . . it's still hard for my dad [to adjust to my sobriety]. He doesn't mean to . . . it just hasn't registered with him no matter how much we talk about it. I'll walk in the house and he'll say, 'do you want a beer?'

Denise describes drinking alcohol at the age of 12. According to Denise, alcohol was "always used to have fun . . . as a shy person, it was very easy . . . to be the life of the party and come out of my shell" while drunk. In high school, she had friends who were older and could purchase liquor, "it was just a part of high school . . . there was a lot of drinking when I was a kid." But, Denise remembers realizing that she drank much more than her other friends. She says she and her friends would "sneak" alcohol into school. According to Denise, she knew even then that she had a problem. Denise states she had tried to quit several times in her twenties during and after college and once during high school. She describes binge drinking during college on the weekends, after finishing college, her drinking patterns increased to "*party*ing everyday." Denise recounts she "*party*ed" harder after college because the "constraints" of going to school had been removed.

She indicates she moved to the West Coast where she continued her old drinking behavior. Denise describes herself as a "serial monogamist" being that she tended to be

in "long-term relationships—one right after the other." She says she apparently "needed to have her identity connected with somebody . . . my identity was often so and so's girlfriend." As Denise's abusive drinking escalated over time, she states she began to have 15 to 30 minute "blackouts." Eventually, their occurrence was frequent enough according to Denise that she had become concerned. She says she would wake up in the morning not really sure where she had previously parked her car. In addition, Denise stresses she felt that she was "lucky" to have not killed herself or somebody else while driving drunk.

Denise mentions she tended to choose men for partners who were "partaking" in drinking alcohol. Between the ages of 22 through 26, she says she was in a "denial party mode." Denise maintains that she entered that four year uncontrolled drinking phase as the result of intense relational loss. She recounts being in a relationship that she thought was headed for marriage, and then, the relationship fell apart. Denise describes this period in her life as being in deep denial in the sense that:

> . . . emotionally I opened up to someone . . . I thought we were going to get married . . . it didn't work out. I had four years [afterwards] having a really good time, while totally denying that I was miserable. . . . there were some really fun times, but underlying all that was an immense sadness that I just couldn't face . . . when you start drinking as 12, you don't learn how to handle anything.

In fact, she says her turning point regarding becoming sober occurred in another relationship where her boyfriend was an active "*party*er." She mentions trying at that time to work on "balancing out" her drinking behavior by attempting to control her daily

intake of alcohol. During that transitional period in her life, Denise says she limited herself to having a glass of wine "every now and then" and by having a "cocoa and Schnapps everyday" after work. Denise describes this phase of reducing the daily dose of alcohol as "playing games with your head . . . justifying" continuing to drink. But, she mentions she would come home from work to find her boyfriend and "people drinking" all around her. She says she finally left this relationship as she became increasingly aware of her behavior with and around alcohol.

According to Denise she began personal therapy as a way to get in touch with herself and her sadness. She describes spending 6 months in therapy before she was able to "open up" and talk about her feelings. Denise indicates she would "talk around it" because she was too scared:

> . . . but once the flood gates were opened, I would sit in the chair and that was all I needed. . . . I just had an immense sadness that had to come out. I had to let it out . . . without identifying what I was sad about . . . it had to manifest itself so the first years of therapy were [long pause and audible sigh] , I hated—I hated it!

Denise says her friends had no idea that she was suffering emotionally as much as she actually was. Denise recounts a sequence in her life when an old friend called her on the telephone:

> . . . a friend of mine called me . . . we were talking . . . of all the gossip about everybody else and out of the blue says nobody ever worries about you—you're always doing fine and doing great. I hung up the phone and started crying. Nobody knows what a complete mess I am. . . . it was very hard to admit to others

> that there was a problem . . . part of my M.O. was—everything is fine—everything is great. I was the only one I'd have to worry about . . . [this sequence occurred] very close to the time I actually started therapy.

Denise refers to her denial prior to becoming sober as a "good mask . . . there was a big mask." According to Denise, when she finally was able to break through her denial and enter personal therapy, she realized that she needed to stop the serial monogamy. She says she spent several years being single working on her recovery in therapy. This was a lonely period in her life, Denise shares these thoughts about being alone:

> . . . and having stopped my alcohol abuse, I've been able to step outside that . . . I am perfectly happy with being an individual on my own, but that wasn't until I had actually gotten to the point that I wasn't a monogamist. I was alone for a while [in order to] have a healthy relationship. . . . I couldn't do that until I stepped away from alcohol . . .to actually take a look at who I was . . . I didn't want to be the person [who was] inebriated all the time. . . . I was mentally lonely even in a relationship because I didn't have the capacity to let somebody in. . . . part of the whole emotional thing and . . .my health related issues . . . were that I was unable to let people past a wall. And it's still something I work on . . . definitely, it's all a work in progress.

Denise indicates it took approximately two years in therapy for her to actually stop drinking completely. She says both of her therapists during that time "never really came out and said, 'you know, what you are doing is not very good for you'—they helped me make that decision myself." She describes her drinking behavior during that two-year

period as "slowing down considerably . . . I'd quit and sneak and quit and sneak." Denise stresses that she became fully sober by abstaining from alcohol more than five years ago after trying to control her drinking and having had several short relapses.

Denise says she maintains her sobriety by "choosing" every day to stay away from alcohol. In addition, she mentions she became a Buddhist in the "midst of all this" transition in her life. The spiritual dimension of her life is very important to her now. She indicates she has learned to "quiet . . . and empty" her mind, which has brought much peace into her daily viewpoint. In her own words, Denise shares her thoughts about the value of meditation:

> . . . getting into my head and quieting a lot of negative chatter—tapes that were rolling around in my head. . . . you sit for 30 seconds and your mind is empty and then you realize that two minutes have gone by and you've been thinking about lunch. And then, you come back and you are quiet for 30 seconds and you come back . . . you sit down every weekend and find that you extend your period of quiet time. So, you'll be quiet for two minutes and then you catch your [mind wandering] sooner and bring yourself back. It's kind of this give and take.

However, the peace of mind seems to balance out inner turmoil, according to the Buddhist philosophy.

Denise says she did not use A.A. at all during the initial phases of her recovery or even now, in her long-term sobriety. Although, she insists that she does relate to some of the ideas in A.A. philosophy. She says she identifies herself in that way to others when discussing her recovery with others. Denise suggests that "it is so much easier to say you

are A.A. or you're a codependent so people can understand" without too much explanation. In regard to her long-term maintenance and her present marriage, she indicates that her husband is a "normal drinker . . . he can have a glass of wine and not worry that there is still an open bottle." She says his normal drinking behavior does not trigger her at all since she chooses to stay sober. Denise stresses knew she had a problem for years and now that she has grown and healed emotionally, she is not about to return to negative health behaviors.

Denise says she thinks that one of the most important aspects of recovery is "having confidence in yourself." Also, according to Denise, women need to be "gentle with themselves" while they are going through the process of recovery. She mentions another bit of advice by stating "be okay or be prepared to. . . take two steps forward and one step back . . . because it is inevitable." Mistakes are a necessary aspect of the recovery process, according to Denise, "I guess some people can cold turkey and never go back, but if you make a mistake cut yourself a lot of slack." Denise says her viewpoint regarding spirituality coupled with her expanding awareness of self has helped her to maintain her recovery.

Frances' Narrative Interview

Frances lives in a city in the Interior of Alaska. She has worked in the field of education for many years. She is a 47-year-old heterosexual woman who has lived in several different cities in Alaska since relocating here in her young adulthood. She even lived out in a "bush" area of Alaska near a river with her husband and child for about 10 years. Get some info on her family to add here. Frances has a 4- year college education

as well as some graduate school experience. She has taught at various levels including college several times in her career as well as other jobs She has had over five years of continuous recovery from alcohol dependence/abuse. Her primary concerns consist of continuing to be a responsible single parent for her teenage daughter as well as having a satisfying career and personal relationship with a man.

Frances offered her participation in my project in the hopes that her story might make a difference for other woman who may be in similar circumstances. We had an hour conversation in a private office at school. Frances was pleased to be of service to other by participating in this research, but she was very nervous about sharing her story with me, especially since it was being recorded. I assured her that our interview conversation was totally anonymous and confidential. Her concerns were very real because she had been through a very difficult child custody case in regard to a divorce, which centralized her former problems with alcohol. Due to her trepidation regarding being heard and/or being found out, she tended to talk in a very hushed tone. She relaxed as the hour progressed allowing her inner personal power and her deeply felt conviction toward recovery to clearly surface.

Frances' Story

Frances describes her racial and ethnic background as Caucasian, she says her father was Swedish and that her mother was raised in the South near a Native American reservation. She recounts a story about when she was a child saying that "when you're a kid . . . getting into trouble [my mother] would said, 'you did this because you are a Cherokee Indian . . ." When being probed for more information, she says, "my sister

searched everybody in our background . . . couldn't find anybody that was Cherokee . . . but we were always told that we were part Cherokee." Frances describes the prejudice in the place where she was raised by stating there was quite a "stigma and prejudice" attached to being anything but "white." Frances speaks of her upbringing as a religious one "attending church every Sunday . . . my mother was Southern Baptist and my father was Methodist. She says she was raised in and still is a member of Methodist church. Frances recalls that her "mother's brother died of alcoholism" [sic]. She indicates her father had three siblings one of whom "died of alcoholism" [sic]. Frances states, "there was an alcoholic pattern . . . but it went far back, but they were drunk on emotions, drunk on control, and drunk on anger."

According to Frances, her alcohol abuse and eventual alcohol dependence began with her experience living in a small cabin out in a rural area of Alaska with her first husband and daughter. She says she was, at the time, a well-educated woman in her mid-twenties who had heard the *call of the wild.* For a ten-year period, she says she lived a rugged lifestyle with no road access, water, or electricity. Frances describes how she and her husband had to cut all their own firewood from their property. According to Frances, she and her husband had to haul in everything that was needed to live out in the woods in a cabin far away from the conveniences of city life. She describes the utter isolation and loneliness of being left alone by her husband for long periods of time with her young child. She says she and her husband both drank and smoked marijuana. However, she indicates her husband's main choice of drug was marijuana.

Alcohol was not readily available while living in the cabin, according to Frances, since they had to walk in everything on a trail. So, she states they both began making beer at home. Frances describes this part of her initial drinking days:

> . . . I made beer and there was marijuana around but you couldn't just go to the store and buy beer. . . . you didn't carry anything with that much water in it . . . the people down . . . river . . . had a well-beaten path . . . but, we kept going past that . . . there wasn't anybody past there. . . . in a way you're protected from [drugs and alcohol] and, also not having any money, I didn't get into things like . . . cocaine. I was out in the middle of nowhere with nothing . . . if you didn't make it yourself you didn't have it.

According to Frances, life for those ten years was very difficult for her on many levels. The obvious daily living hardships along with the severe isolation, and Frances says that her deepening alcohol dependence played a role in what took place next in her life. She says her husband died young at the age of 33 from lung cancer. Frances states she was 31 years old at this turning point in her life. She describes this horrible experience as "tragic." After her husband's untimely death, she indicates she and her 5-year-old daughter moved into town. This is the time period in her life, according to Frances, when she says her drinking behavior escalated. For the next two years, Frances mentions abusing alcohol every day. Frances describes her drinking life after her husband's death by relating this account:

> . . . he went really quick . . . very quick, so after he died I moved to town and I got a job . . . I drank every night and blacked out just about from the beginning. I

> don't think that is the average for most people . . . that starts in the later stages of the disease . . . one morning I woke up with a cut on my chin. I was drunk and had fallen out of my chair and hit the table. I would walk around the house and look at things [I] had done the night before. The evidence was there, that you made dinner, that you didn't clean up the dishes, that you fell asleep with the light on . . . the T.V. on . . . you could . . . track what kind of things and see what you had done the night before . . .

Frances also describes another sequence regarding the severity of her blackouts when she recounts inviting friends to her house for dinner:

> . . . having someone to dinner in our little one room cabin . . . after I got sober the first time, this friend who had come over for dinner said that I would do things like (very long pause) dish up beans on my daughter's plate and then give him some and come back to my daughter's plate and give her a second helping right afterwards. . . . apparently, I just functioned . . . kind of normally, but . . . no one was looking at me and saying, 'you drink too much' or 'you're too rowdy' . . . 'you're not doing what you are supposed to be doing' . . . I was doing a 40-hour a week job, raising a kid by myself, living in a one room cabin, getting all my wood . . . chopping all my wood, dealing with the wood . . and doing more or less okay at work.

When Frances got sober for the first time, she says the change was instigated because she wanted to quit drinking and found that she could not stop. She describes wanting to "do a better job at work . . . to be more alert, and not be wasting time drinking . . . because [she]

wasn't getting anything creative done . . . and wasn't enjoying it." After she realized that she was not able to quit by herself, Frances says she entered a 30-day treatment program outside of Alaska. Apparently during the mid-80s, according to Frances, there were no 30-day treatment programs in Alaska where one could use their insurance. She says when she returned to her home after treatment, she attended A.A. meeting twice a week.

Frances says she has two stories of alcohol dependence/abuse that are woven around her two distinctly different marriages. She says her second marriage was to a man who also drank. Frances speaks of gradually slipping back into her old drinking behavioral patterns in that marriage. She maintains she also stopped going to A.A. meetings. Her second husband was physically and emotionally abusive, according to Frances, to her and her daughter. She mentions when she met her second husband he was raising a son from a former relationship to an Alaska Native (Eskimo) woman that he did not marry. Frances says she and her husband eventually had a daughter together as well. She states she was raising three children at the same time she was trying to deal with her problems with alcohol. Frances recounts over time her relapse into drinking deepened. She mentions she also had stopped using A.A. and became very involved with her church. As a result of her church involvement, she says she decided to live a sober lifestyle. This time, though, she describes once again that she could not quit on her own. By this time, she says her former A.A. training became more relevant to her because:

> . . . there is a theory that if you quit drinking, your disease progresses just as if you had been drinking. If you are drinking a bottle of wine when you quit, then seven years later when you start drinking again, your disease would have

> progressed so that you'd be doing a 5th of vodka . . . even if you had quit in between . . . and had seven great sober years, your disease is still at the same place it would have been if you had been drinking . . . and I found that to be true.

Frances' insists her dependence on alcohol was much more profound the second time she tried to become sober. As a result, she indicates she voluntarily went back into treatment. By this time there was a treatment facility in Alaska, according to Frances, but she says she had to leave her home to attend. She mentions spending another 30-days in treatment. Frances describes her experience of this round of treatment as like:

> being in a prison . . . we were living in the old school. It was on old building about three or four stories. You had a roommate and had to keep your room clean . . . had inspections, regular classes, no caffeinated coffee, . . . and vitamin therapy. I tried to leave when I first got there, but it was never a question . . . that's the first thing they say to you . . . 'we already got you on our list, the insurance is going to pay for your trip down here . . . if you stay 28 days . . . if you leave, you will have to pay for the whole thing. You will have to pay for the whole trip . . . it's a hook.

After the treatment program, Frances says she returned home and began aftercare by attending A.A. meetings and once a week group therapy sessions.

According to Frances' her second and final treatment for getting sober worked. But, she stresses that it had taken its toll on her marriage. She says she wanted out of the marriage very badly. She indicates she was in a depressed emotional state directly prior to seeking treatment again. Frances describes this portion of her story by stating:

> . . . that was all about dealing with the whole complete and utter failure in my marriage . . . I was married to this guy . . . looked good on the surface. I was raising three kids and I felt responsible. I didn't want to break up the family. But I didn't want to live in a house that was THIS marriage. I didn't want to raise that boy for another nine years! And I didn't want to . . . have my kids see me as a person who was an absolute failure. I didn't have a job outside of the home. There was no recognition of anything I was doing. You can cook and do all the laundry and shop . . . keep the kids running back and forth . . . but it wasn't earning money. I didn't deserve vacations because I didn't have a job. . . . I [would wonder] 'what am I going to do with all these vodka bottles?' I'd put them in the neighbor's trash or along the highway. . . . and making vows that one by one got broken. 'I'll never drink and drive.' I'll never ever have my kids in the car.' One by one you just tick all those things off and . . . do them anyway despite being really against them. And the guilt . . . (audible sigh).

Frances says she now knew that she had to get out of the marriage. That was not very easy, according to Frances, because her husband was vindictive and abusive. She states the divorce involved an extremely difficult and painful child custody battle. She mentions that her husband had not wanted it to get out that she was in recovery for alcohol dependence/abuse. But, when it did, according to Frances, he turned it against her by having a court order issued to monitor her drinking behavior. She says she had to submit to a weekly urine analysis at $25 each for a year during the court case. Frances

describes the whole process as "degrading." She recounts she also had to submit to a psychiatric evaluation. Frances says she became very bitter at this point in her life:

> I'm an alcoholic . . . that makes me crazy, right? The judge said that if I had to get [an evaluation] that my husband had to get one too. . . the really incredible thing about the whole deal was that everything he wanted it to say about me it actually said about him . . . the 95th percentile for abusive child molestation . . . 95 percent of people with that score are abusive to their children. . . . there's a really fine line between taking responsibility and laying blame on other people . . . he didn't think of A.A. as being something positive. . . he didn't want anybody to know that I was an alcoholic . . . all of the things that keep you in a secret, that keep you from being able to stop and follow the recovery program . . . at that point I bought into all of that. . . . I didn't get a new [A.A.] sponsor . . . I didn't go to meetings . . . I stayed at home alone and didn't work . . .

Although the court process was very difficult for Frances, she says she obtained her divorce and retained custody of her daughter. She describes how she now is on the road to full recovery from many years of alcohol dependence/abuse.

Frances says she maintains her sobriety one day at a time. She asserts she follows the philosophical viewpoint of A.A., which means that she attends regular meetings. She has been sober (abstinent) for over five years. Frances insists her definition of recovery involves complete and continuous abstinence from alcohol. She says she reads and studies the *Big Book* of *Alcoholics Anonymous* (A.A., 1976), as well as actively works the twelve steps (Appendix D) of the program. She mentions that during her first attempt at

living a sober lifestyle, she "didn't value" the methods used in A.A. However, she says she is committed to her sobriety now and has learned to appreciate the A.A. philosophy.

In addition to A.A. meetings, she indicates that she attends Narcotics Anonymous (N.A.) meetings as well. N.A. follows the same format as A.A., according to Frances, but its membership is comprised of people whose process of addiction has involved drugs or drugs and alcohol. She recounts her experiences in N.A. in the mid-80s during her first experience with long-term recovery:

> . . . the first time [in recovery] I went to a lot of meetings, two a week and made close friends from the women's group. And I went very regularly to a meeting that was so big you weren't recognized. . . . interestingly enough, the . . . women's group was N.A. . . . which has been in the past and even now was a more rockin'-n-rollin' thing than A.A. in [this town]. There were really strong women at the time in the 80s who were in recovery . . . there is . . . acceptance on the N.A. side for people who have an alcohol problem, but it is not reversed . . . people in A.A. [tend to insist] this is about drinking and they don't want you to say anything about using drugs . . .

Frances says she still organizes her weekly life around attending meetings. She indicates that the type of friendships you can develop through being affiliated with A.A. and/or N.A. help sustain one's resolution to be sober. She says she also believes in order to make major changes such as recovering from addiction it requires becoming:

> . . . teachable . . . I think the thing you learn when you go to a lot of meetings is not only do you develop friendships that keep you sober, but you start to

> recognize a part of your story that is like other people's. So, it helps you to identify a lot of things about yourself and that you never would have realized if you didn't stop and listen to people.

In addition to A.A. and N.A. meetings, Frances says she has been enriching her friendship base by going back to school to acquire a graduate degree. She mentions keeping herself busy with positive choices now. She mentions how she and her daughter are living a healthy life free from the "insanity" of alcohol dependence/abuse.

Frances says she has several concerns related to women and alcohol dependence/abuse to share. First and foremost, according to Frances, is the potential damaging ramification of women being "isolated" from others. She says she is referring to three types of isolation from her own experience: (a) location—such as living removed from others in rural Alaska, (b) relational—social expectations of a mother and housewife to be primarily in the home, and (c) self-imposed—staying at home due to the cyclic quality of addiction and depression. Frances says that women tend to be "much more isolated" when living in an abusive alcoholic relationship. According to Frances, women with children in a relationship have very few rights, even if they are in a legal marriage. She indicates that marriage itself has additional constraints such as negotiating an equitable divorce and child custody. She explicates her thoughts on this idea:

> . . . as a woman, as an alcoholic you have no rights, but (long pause) as a woman, there were a lot of specialty things because of that relationship. . . when the police would show up if it was a female police officer there was not a problem, but there aren't very many [women police officers], . . . but, if it was guys, [they would say

> to my husband] . . . 'hi, how ya doing?' . . .then whatever was going on they wanted to arrest me . . .he threw me off the steps and they would want to arrest me. . . .you have no rights as an alcoholic woman.

Frances posits she thinks it is very important for "women to share with other women." In regard to the A.A. program, she describes a saying that some women tell other women in meetings, "realize that guys will 'grab your ass . . . but, women will save your ass." She says she was "amazed that women don't trust other women." Frances stresses, "women [who are drinking] are still using sex as a manipulation and control . . . [they] use it as a cover-up . . . they get tied up with guys [who drink] and it get so messy."

Jesse's Narrative Interview

Jesse lives and works in a large city in the Interior of Alaska. She works in a university environment and is also a non-traditional student in the process of completing a 4-year degree. She is a 43-year-old homosexual woman who has lived in the Interior of Alaska for approximately 10 years. She relocated to Alaska from the Pacific Northwest region of the U.S. and has maintained recovery from alcohol abuse for over 17 years. She said that her change in behavior regarding alcohol abuse occurred so long ago that she had almost forgotten certain aspects of the process. The interview conversation stimulated memories she hadn't thought about in a long time.

Jesse wanted to participate in my research in order to help others who may have similar problems with alcohol as she. We met at a mutually agreed upon location away from my research office because it was difficult for her to get together during work hours. Our conversation was punctuated by the sound of thunder, rain, and wind. There was a

storm raging outside as she dredged up memories like ghosts from the past. The interview lasted for about an hour during which she recounted her tale of teenage alcohol abuse that spread into her young adulthood.

Jesse's Story

Jesse says she was raised in a family where her father was an alcoholic, but the mother was not. She states she is the middle child out of three. According to Jesse, she was the only sibling to have an alcohol problem as a teenager and young adult, but she says her younger brother participated in her early teenage alcohol abuse. According to Jesse, he tends to like beer and even brews it himself, but she says she is not sure if he continued abusing alcohol as a teenager since she had moved away from the home environment.

Jesse indicates her racial and ethnic background is primarily Caucasian—German and Dutch, with 1/8 Native American—Cherokee. She says her father's maternal grandmother was "full-blooded Cherokee from the Carolinas." Jesse describes her father as "a lifelong beer drinker," in fact, the secondary cause of his death was cirrhosis of the liver due to alcoholism [sic]. Jesse mentions that her parents divorced when she was between eight and nine years of age. She stresses that her father's drinking behavior was out of the home environment at that point. In her teens, Jesse says she remembers having telephone conversations with him when he was drunk:

> . . . he was on the other end . . . slurring his words and you knew right off that he was drunk. . . . he had five brothers all of whom were alcoholics. He had two sisters, but I don't know if any of them drank. It definitely runs in our family . . .

> and it was my dad's behavior partly that helped me stop for quite a long time and then to control [my intake of alcohol] since once in awhile I have a beer, but I certainly can live without it now.

Jesse states that her mother did not abuse alcohol. However, she says her mother's brother is an unrecovered alcoholic who has just turned 70 and is very ill from alcohol dependence. Jesse describes her mother's use of alcohol as "once in a blue moon." Jesse says her maternal grandfather and grandmother were not alcoholics, but most of her grandfather's five brothers "drank heavily." Two of these brothers, according to Jesse, "truly abused alcohol and never recovered from it." In fact, she states one of her great uncles on her mother's side died from alcoholism [sic]. She says he was in his early 70s when he passed away. Jesse indicates that alcohol abuse was prevalent on both sides of her family, but closer by generation in her father's family.

Jesse describes her father as out of control and as an angry person when he was intoxicated. According to Jesse, she remembers one sequence in particular as a young child where he was drunk and abusive:

> . . . there were a couple of incidences in particular that I will never forget where he was drunk . . . and he was a belligerent drunk . . . he was mean and physically violent. He was yelling at my mom for something and I don't even know what. I don't remember him hitting her in that instant but he grabbed her and opened up the hall closet and pushed her into the hall closet and shut the door. I was little like 5 or 6 and I ran over to the hall closet to open the door to get my mother out

> . . . at the same time he turned and grabbed my sister who is 5 years older than me and threw . . . she fell against the swinging bar doors between the kitchen and dining room. She fell against those and I don't remember anything beyond that. I think he just left after that. He moved out – I think my mom kicked him out. If I remember anything about how it affected me as a kid, that was the one incident that I will always remember. But as [long sigh] those negative things that you try to suppress . . . I think that occurrence was suppressed for so long that I wasn't really cognizant of my father's alcoholism [sic] until I was 15 and drinking.

Jesse says she considers her own abuse of alcohol as a "socialized" situation where it was "normalized" by her father's example and then, "fostered in the social environment" in her high school experience. Jesse mentions her abuse of alcohol lasted approximately six years, ages 15 through 21. She maintains that there was a four- or five-year period after she quit abusing alcohol, but continued to be immersed in drinking and addictive behaviors in her living environment by being in relationship with partners who abused alcohol and drugs.

At the age of fifteen, according to Jesse, she says she began a six-year period of consistent alcohol abuse. She mentions not knowing if she was actually alcohol dependent during that period of time, but was "definitely abusing alcohol." She says her drinking career began in high school during a time when she was an athlete. Jesse recounts how her fellow athlete friends and she would "drink beer" after their long physical workouts. The drinking occurred primarily on the weekends, according to Jesse, but by the time she entered college and began working, she says her alcohol bingeing on

the weekends began expanding to include weekdays. Jesse describes a typical sequence of her early drinking behavior:

> . . . my personal experience with alcohol abuse began at a pretty young age. In high school I was an athlete and in the summer times we practiced every evening and practiced every weekend from about 8 am in the morning until about 6 or 7 at night. . . . We would sneak away from the ball field and walk across the street to the local liquor store and I guess I was the one that looked the oldest, so my buddies would talk me into either talking people to go in to buy beer for us, and quite often, we would see older guys from the ball field who would buy us beer. So, I feel like I began there. . . . Then it escalated throughout my high school career, especially, when I was playing sports. I considered myself kind of a weekend warrior when it came to drinking. By the time I was 17 when I was a senior, I had gone to so many athlete parties where we drank to excess . . . where I spent a number of Saturday nights on the bathroom floor hugging the toilet. And then, not remembering . . . the only way I knew this was that my friends would say, 'boy, you really got shit-faced, do you realize what you did?' . . .

By the time she entered college and was working part-time, according to Jesse, she states her binge behavior with alcohol was a set pattern lasting for several years. She says her alcohol binges were initially weekend occurrences in that:

> . . . on a Friday or Saturday night it wasn't like I would have a beer or two, we kind of joked about me being able to down a 6-pack of beer without a problem in an evening. Actually, from the time I was 16 until I was 21, in addition to

> drinking beer . . . I smoked a lot of pot as well . . . I kept it to the weekend. A couple of times when I was working I did go out for lunch and my problem was that when I drank it wasn't one or two beers. I would have either a pitcher of beer from the pizza parlor, it was never just a beer. I was one that had difficulty stopping. I had a couple of lunches at the pizza parlor . . . and went back to work shit-faced drunk. I had a job where I dealt with supplies and thank god for my supply room. I ended up spending the afternoon in my supply room cause I was drunk – I could not function. But I didn't want to take the time off or call in sick for the afternoon. But there was no way that I was going to let my *having fun* and drinking get in the way of my job.

Jesse says that when she was 18, she and her brother visited her father for two weeks. During this visit, Jesse describes how she and her 14 year-old brother drank with her father in his apartment. She recalls this episode of her life:

> . . . he picked up my brother and I and took us back to [his home] for a couple of weeks. He was very blatant about his drinking. He was one who drank in the evenings when he came home from work. . . . I said to him, 'hey, I bet I could buy some beer, let's go down and buy some.'. . . he said, 'no way, you can't do that.' . . . 'sure I can just give me the money and I'll go into the liquor store because the people think I am old enough.' So, my little brother, my dad and I drove over to the liquor store . . . I went in there and a couple of minutes later came out with his 6-pack of Coors beer and my little bottle of two fingers Tequila. He just laughed and we thought that was just the best thing. He got a big kick out of that. We

> went home to his apartment . . .god, I even think that [my brother] drank! . . . he was only 14. I proceeded to get drunk with my dad. That was the one and only time . . . thank god. But, I had thought that was a fun time. It was one of the few things I could share with my father!

Jesse mentions that as her alcohol abuse escalated during her early twenties, some of her friends began saying things to her about her behavior. One time in particular, according to Jesse, is a prominent memory:

> . . . I was hanging around so many people who were as into alcohol as I was. It's not like I had an avenue. Those that I hung around with . . . I just did not have that avenue. There was one friend in particular . . . when I spent one weekend hugging a toilet and then also spent a lot of time in the shower with her trying to sober me up. Apparently, I was delirious from being so darn drunk . . . I think it scared her enough that a couple of days later when I actually was coherent again, she came to me and told me, 'you don't get to do that around me anymore!' And she was actually a very good friend and a pothead in her own right. She didn't drink. But other than that I hung around with people who were as into it as I was.

When Jesse actually was able to start looking at her own drinking behavior, she says it was as a result of her observing the same kind of behavior in others, especially in her intimate relationships. According to Jesse, she says it was during her first two significant relationships with partners who abused alcohol and drugs that she was able to reconsider her own behavior.

Jesse mentions she quit abusing alcohol during her first serious relationship with a woman whose "choice of abuse was marijuana and beer." She says that it "made her sick" to watch her and others abuse alcohol to the point that they were sloppy and/or belligerent. In fact, Jesse says she thinks that this particular relationship triggered her awareness about her own alcohol abuse:

> . . . it just made me sick to watch others do that. And I think it helped me see what I was doing by observing their actions and their behaviors. . . . I think that stopping drinking at that level for me was a decision I made myself. The outside influence came from conversations with my dad who was drunk quite a lot. . . . I sure was caught up in it. I think a year or two before he died I was really trying to take care of myself and step away from that. I really tried to get away from that environment. And the person I was living with who drank Heineken all the time . . . she was a cocaine addict . . . the best thing I did was to separate from that environment. I moved from there . . . and hooked up with people who pretty much didn't drink. We found other things to do to help us have a good time.

Jesse says she began to control her drinking at this point in her life. Up until a special weekend experience during her first significant relationship, Jesse indicates she was in the process of changing her behavior, but had not completely stopped drinking. She says she and her partner had become very active in a local gay church. Jesses recalls that socializing was a major aspect of her affiliation with the church besides she describes being enthralled by a very charismatic minister. Jesse says she and her partner joined in on the church's annual weekend retreat. Jesse describes becoming disenchanted with her

partner's alcohol and drug abuse by this time. She says she joined a group of women at the retreat that were in a recovery group. She mentions learning about the A.A. recovery process on that intensive weekend retreat. Jesse describes her experience of that weekend:

> . . . nowadays I don't really believe in organized religion much but oh, god this [minister] was just incredible . . . I was with someone who also drank a lot and smoked pot . . . she drank a lot of beer. We went to this . . . retreat in an old girl scout camp. . . . one of my very good friends, was in AA . . . she was in recovery. When we got there [my friend] said, 'hey, I put us in the AA tent . . . because we want to be with people who are in recovery." [my partner] pitched a little bit of a fit about it . . . she had no intention of stopping all the drink and all that. But I was thrilled to no end. I met some wonderful people . . . through those folks who actually attended AA meetings I learned a lot. I don't do well with organized anything. I gotta do things on my own. That was quite an experience – it was a wonderful 3-day weekend. Definitely an intensive. . . . we stayed in a tent cabin with about 10 women who were in recovery . . . when I was spending a lot of time with the other women who were in recovery, [my partner] was sneaking off to smoke marijuana down by the river. . . . it was quite a juncture in my life . . . Because I didn't have the exposure to any alcohol anonymous type of meeting or that type of environment. No exposure to any type of recovery groups of any kind at that time . . .

After that weekend, Jesse says that her disenchantment with the abusive alcohol lifestyle escalated. She describes this budding awareness of wanting to change her behavior through her observations of others in that:

> . . . I did it on my own. Actually, that is the main reason those relationships did not continue. It was difficult. For me it got to the point where I had absolutely no tolerance for it and quite often I came home from work and there my partner was with a friend or two hammered out of their gourds or smoking marijuana. I was tired of my clothes and everything smelling like pot. . . . I had spent so much of my life prior to that being an athlete and a successful athlete that I was trying to be physically fit again. I was riding a bike a lot and being healthy and changing my ways. Ways that didn't include drinking.

Jesse says she found that trying to control her drinking was not working for her initially. Later, Jesse says she was able to quit drinking "cold turkey" without much apparent problem. She indicates that her experience of realizing that she needed to just stop her alcohol abuse developed gradually over time. She says her own abusive behavior while being drunk seemed to shock her into a change:

> . . . there were several occasions I had a little too much to drink like 2 or 3 beers on a weekend. And I didn't like my behavior. I wasn't like a fun loving kind of happy-go-lucky drunk. My dad was a belligerent bastard when he was drunk and physically violent . . . I was a caustic, rude, and on the verge of physically violent person. . . . it was something that I didn't want to do. . . . when these couple of times occurred then . . . the next day it was a great revelation that I needed to take

> the emphasis off it. . . . It is not simply how alcohol affected me physically or mentally but how it affected my father and my family as well . . . I always think about that.

It has been over 17 years, according to Jesse, since she was able to quit abusing alcohol. After a few years of abstinence from alcohol, she says that she intermittently will have a beer when out to dinner with friends, but she insists she has never resumed her previous binge drinking alcohol abuse.

One of the most important aspects of recovery, according to Jesse, is choosing not to be around people who drink abusively. She says she used to "interview" potential friends about their drinking behavior before getting to know them. If new people in her life had any hint of a drinking problem, she insists she would terminate the connection or distance herself. She indicates she deliberately began choosing close relational partners who were as opposed to alcohol abuse as she had become. She says she has been in a long-term relationship for over 14 years with a partner who does not abuse alcohol or drugs. Jesse says that a person's drinking behavior is still high on her "list" when it comes to making close personal friends. She says that none of her current friends abuse alcohol or drugs.

Jesse asserts that an evolving sense of spirituality has become the basis for her outlook on life. Over the past fifteen years, she says she has begun to tap into her Native American roots. She recounts a story when she had a vision one evening while relaxing in a hot tub out under the open sky and stars where she was living at the time in the Lower 48. She describes that she saw the shape of "three wolves" spread across the night

sky pointing to the North. Jesse says that there was no doubt in her mind, "right then, I was supposed to follow the essential nature of the wolf." Jesse says she began a spiritual quest that night that has been evolving ever since. She stresses that one of the main reasons she moved to Alaska was to follow the very personal message in her vision. In regard to long-term maintenance of her recovery from alcohol abuse, Jesse says she knows that her deep spiritual sense of connection with the Earth and its wildlife keeps her from ever choosing to return to a negative pattern with alcohol or substance abuse.

Jesse states her main concern for women relates specifically to gay women. She says her experience with recovery was specialized toward the lesbian in recovery. Jesse states that the church she attended for five years had a lesbian minister and gay fellowship, both men and women. She says she does not know what it would be like to seek help from a recovery organization that did not recognize or support lesbians. According to Jesse, she says it was extremely important to her:

> . . . to be my natural self at that initial A.A. retreat with my church group. I would not have been willing to join in the group or process of the group afterwards if it had been just a general group or primarily a straight group. My ideal group would be around 8 to 10 gay women in recovery . . .

In that respect, Jesse says she urges women no matter what their sexual orientation is to seek help and support from organizations that will support their religious and/or spiritual outlook as well as their relational lifestyle. She also insists that getting the kind of support that a lesbian needs might be "more difficult in a conservative town." Jesse suggests her advice is to surround oneself with positive people who are leading the

lifestyle that one hopes to lead. Jesse says, "do the research . . . find people of like mind and spirit so you can achieve success in your desired changes."

Amanda's Narrative Interview

Amanda lives in a large city in the Interior of Alaska. She is a 35-year-old heterosexual woman.. She works as an administrative assistant in an educational setting. Amanda has more than 11 years of continuous abstinence from alcohol dependence/abuse. Amanda has a desire to go back to school to become a nurse in order to commit her time and service to the people in the rural town in Alaska were she was raised. She wants to work directly with the elderly. However, Amanda indicated that she has worked well with adolescents and families in the past and could work with them as well.

Amanda was very nervous about being interviewed. She missed our first appointment to meet at my office because she had gotten evicted from her apartment that very weekend. She had moved into a friend's place for a while. Amanda did not contact me to break the appointment. I waited for over an hour and finally went home. I contacted her by telephone a few days later to hopefully set another appointment. She said that she wanted to do this interview very much, but could only meet me at the parking lot of a local supermarket during her lunch hour from work. We agreed to meet the next day. We met in my car in the supermarket parking lot at the designated time.

Amanda seemed very nervous during the entire interview and kept looking out the window. It did not occur to me at the time that her boyfriend might be near us in a car. But, when we finished our conversation after about 45 minutes, she got into a car that

was driven by a man. I assumed that it may have been her controlling boyfriend. And that is perhaps why she appeared to be on edge during the interview. This was not an ideal situation for our interview. However, I did not want to lose the opportunity to talk with her and hear her story of recovery and maintenance of long-term alcohol dependence/abuse. She gave much valuable and insightful information despite the limitations in her current relationship and lifestyle.

Amanda's Story

Amanda says that she had relocated from a small village in rural Alaska to raise her children, to work, and eventually return to school to pursue her dream of becoming a nurse. She describes her racial and ethnic background is Alaska Native—Athabascan. Amanda indicates she is the 13th child out of 14 children and was raised in an alcoholic family where both parents consistently abused alcohol. She states her father died from cirrhosis of the liver and her mother died from a heart condition, which was related to chronic dependence/abuse of alcohol.

She says she was "fostered in another family . . . by relatives . . . who also were alcoholics and abused alcohol." Amanda describes her experience of her upbringing as:

> . . . raising myself . . . I raised myself because my parents were drunk all the time . . . they didn't care . . . if I didn't watch out for my son and my girls like I had nobody to watch out for me . . . [long pause] . . . I read Velma Wallis' new book, [Raising Ourselves] . . . much of what I read I could relate to since I grew up in an alcoholic home myself.

She says her siblings struggle with alcohol problems as well.

Amanda describes drinking at the age of 11, but says she did not drink consistently until she was a senior in high school. She states she would "go to school drunk . . . with hickies" on her neck. Amanda says her abuse of alcohol at that time was so severe that she "blacked out" often.

Amanda recounts a story about her black outs that she says will haunt her for the rest of her life:

> I think I was out of control . . . I didn't have control of things at the time. But, I was just lucky that I didn't have any run ins with the law . . . or getting raped or beat up or even killed . . . I was drunk one time and I blacked out . . . there was hot water on the stove . . . I don't know what I did, but when I came to my face was all burned . . . I had to get a skin graft [on my neck] . . .

Amanda says she had to move to the city for treatment of her burns. She indicates that she lived with her brother and his family and finished high school there.

Amanda says that her alcohol abuse continued after she healed from her surgery. She states she had been referred to treatment while in the hospital, but the changes did not last. According to Amanda, she says she moved to a town in South Central Alaska to complete vocational training. She indicates she was kicked out of the school for drinking. Amanda says she also worked as a health aid during that period in her life. She described the incongruity of this experience:

> . . . I worked as an alcohol and drug educator for one year when I got out of high school. I resigned from that job because I wasn't living what I was teaching. I was teaching them from the book, but it wasn't from my heart or from my brain.

> I wasn't living what I was teaching those kids. So, I didn't think I was fit to do the job . . . and, then I went to Job Corp . . . I graduated from Job Corp as a health care worker. And I never did anything in the health field after that.

Amanda describes her alcohol abuse as escalating during her late teens and early adulthood. The alcohol abuse got so bad at one point, according to Amanda, that she says she was "living on the street." She asserts she was drinking every day during that period. She describes this part of her alcohol abuse as:

> . . . just getting drunk . . . I had some hard times . . . drunk. . . . I was in a bar and must have passed out . . . I didn't know why or how I had left the bar with [a man] . . . when I came to, he was on me in a field . . . I had half a pint in my jacket. I pulled it out and gave it to him . . . he let me go. . . . that was one close time for me, but I never got into any trouble with the law.

Amanda says she continued her abusive drinking behavior until she became pregnant at the age of 19. She indicates she found out she was pregnant about a month into her pregnancy and quit drinking immediately. Amanda mentions she resumed drinking when her daughter was about 4 months old. She says she gave the baby up for adoption since she had no means of support. Amanda says she abused alcohol for another 6 months until she got pregnant again with her son. She asserts she stopped drinking once again and has been sober (abstinent) ever since.

During her pregnancy with her first son, according to Amanda, she says she went to a church in a rural village with a good friend. She says the minister's wife became her

friend during the first few months of her renewed sobriety. Amanda insists she made a significant breakthrough regarding her own behavior with alcohol due to this experience:

> . . . I was really hating that I was isolated with my small children. I really needed that [friendship to the minister's wife] . . . she would come pick us up . . . then, she wanted me to take Bible study. I agreed to it. I think I signed up the second or third week . . . [it was then] I asked Jesus to come into my heart.

Amanda says she changed her life at that point. She asserts that she has not returned to alcohol abuse, but has come close several times. She says she believes that her connection with the "Lord" continues to keep her sober despite a current difficult relationship with a man who abuses alcohol.

Amanda says she has been able to maintain long-term recovery from alcohol dependence/abuse for over 11 years, yet she describes this process as extremely difficult for her. Approximately 5 years ago, according to Amanda, she says she began a relationship with a man who drinks. She wonders why she allowed herself to get involved with an "alcoholic." She says they have had two children together. Amanda describes her own long-term maintenance of recovery from alcohol abuse has come into jeopardy since she has lived with him. She states her confusion regarding her own choices about staying in this difficult relationship:

> . . . right now I am at a point where it is a struggle just to get by day to day. I don't have any of my kids with me right now. We got evicted . . . because my boyfriend's been drinking. We've been together now almost 5 years and the whole time he has made my life miserable. His drinking . . . as soon as I find out

> he's been drinking, I get mad. I used to do this at home when I'd come home from school and my parents were drinking I would get really mad . . . really deep anger and I was afraid and said hurtful words. And I do this with my boyfriend. . . . I want to break up with him. But right now, I don't know . . . we are really dependent on each other. We're going through a hardship. He is being fair with me, but he is an alcoholic. He did change some regarding my kids, because I wanted to break up with him. . . . I can't leave him. I guess I need him for the love, I guess. But I know I could make it without him.

Amanda says she has stayed in the dysfunctional relationship with her boyfriend, but she mentions has been able to maintain her sobriety (abstinence). She says she has come close to drinking again several times during the past 5 years. She insists she knows that she needs to get out of this relationship. Amanda describes having a good job and pays her rent and groceries, but she says she allows her unemployed boyfriend to control the remainder of her monthly salary. When asked how she could possibly hang on to her sobriety during the turmoil of being evicted from her apartment, not being able to take care of her kids, and her boyfriend's careless spending her money, she insists:

> I keep telling myself this is not the kind of life I want. I want to be there for my children. Every time I start thinking about alcohol, I think about my oldest daughter and how devastated she would be if she saw me drunk. None of them have seen me drunk before. My daughter is 12 and my son is 11. They never saw me drunk in their lives. . . . what are they going to do without their mother? . . . who's going to take care of them? . . . nobody can love them the way I love them

> . . . my parents weren't there for me . . . I have a strong will to refrain from drinking.

Amanda says she refuses to resume her former drinking behavior. She states she has entered counseling recently with a personal therapist who wants her to get couples counseling as well. Amanda describes being open to the idea of seeing a therapist with her boyfriend. She says that she is "at the point where he has brought [her] down too many times," but is afraid that she won't be able to avoid allowing him to continue to drag her down even further. She describes her attitude about this fear:

> . . . it is a struggle with him. I only maintain it being beside the Lord. . . . when things go bad . . . I ask Him to take control of the situation then things start to calm down. My boyfriend tries to get me to drink sometimes. . . . but he's never seen me drunk, I was bad when I was drunk . . . I don't ever want to walk down that road again.

Amanda says her religious and spiritual convictions seem to be her only support through this part of her journey in recovery. She insists she does have faith that the "Lord" will guide her through these hard times.

Ester's Narrative Interview

Ester has been living in a large city in the Interior of Alaska for six years. She is a 60-year-old heterosexual woman who relocated to Alaska from the U.S. West Coast. She has a degree in homeopathy, which she earned in Europe. However, her degree and credentials are not legally recognized in Alaska. She intends to work solely with women who are in recovery from alcohol dependence and/or abuse. Ester is a gifted healer. She

decided to complete a 4-year degree in Alaska so that she can continue her healing work. She has been teaching adult classes in a university setting while attending college. Ester's healing work with women involves a holistic approach to recovery from alcohol abuse. Ester has maintained her abstinence from alcohol for 22 years. She is totally committed to her personal recovery and the successful recovery of others.

Ester and I weren't able to agree on a time when we could meet in person because our schedules seemed opposite from each other. In addition, Ester has multiple sclerosis, which causes her to get tired very easily. After several failed attempts to meet, we mutually decided to try a telephone interview. We had a lively exchange over the telephone. The audio-recording was crisp and clear. I could even hear her long sighs and pauses when preparing herself to share her story about difficulties with alcohol. Our conversation lasted for approximately 90 minutes. As we decided to end the interview, we both agreed to try to meet in person since we felt as if we had more to discuss. During a follow-up meeting, we drank coffee while sharing our mutual passion regarding recovery issues for women and the value of spiritual growth.

Ester's Story

Ester says she was raised in two different foster homes by the time she was five years old. She indicates she did not know her parents very well. According to Ester, she says her parents were "poverty-stricken" and "split" when she was quite young. She recalls that her parents visited her on and off or just "slipped" through her life from time to time during her childhood. She says she lived in the same foster home with an aunt until she left home at the age of 16. Ester describes her racial and ethnic background as

including "Dutch, German with a strong possibility of being Jewish, but not sure . . . my father was Tsa-La-Gi (Cherokee) . . . his mother was full-blooded and married a Chocktaw and English man." Ester speaks with much pride and reverence regarding her Native American roots.

Ester indicates that her father was an alcoholic. She says she was exposed to alcohol before she was 16 years old. She says she remembers her head being lower than the seat on a bar stool in the bar:

> I was just a teeny little kid and he used to drink Pabst Blue Ribbon . . . he used to give me a little beer when I was 3 or 4 years old. Of course, having the gene for it that was the set up there . . .that was the first exposure and I remember loving it. I didn't have a problem with it burning my throat and all that.

Ester indicates her first foster home was very abusive. She says her abusive foster mother threw her down a flight of stairs. She states she and her two brothers were removed from that foster home when the abuse was discovered and were placed in a foster home with her father's aunt. She describes loving it there, but the aunt was a prescription drug addict and gave them valium to calm them down. According to Ester, by the time she was 16, she was "hooked" on valium and was a "full-blown alcoholic and drug addict." She says she participated in the drug culture of the 1960s and identified herself then as "a really good hippie." She mentions she returned to her aunt's home when she was the age of 20 and pregnant.

Ester says she stayed at her aunt's house until she was nine months pregnant. As soon as she delivered her daughter she had to go to work. She describes working two

jobs to make ends meet. She says she has done that all her life, "been a workaholic." She describes working in a factory and working as a waitress in a coffee shop in the mid-west. According to Ester, she asserts the mid-west was a:

> . . . horrible place to get stuck. They should bomb the place . . . it is one of those little ignorant horrible back woods cities that is, oh, god! . . . I had a real work ethic and tried to be as good a mom as possible under the awful circumstances . . . I met a guy or two once in a while, but really wanted to get married.

She indicates she did drugs and drank and came home at night to be with her child. At that time, she says she worked at a portrait studio and wanted to become a photographer. Ester states she was able to work as an airbrush artist in the studio. She says she was being trained at another studio to be a photographer and a retoucher when she met an older man. She recalls he was 45 and she was 21. Ester states she married him. She refers to this marriage as a "convenience marriage." She says he was a diabetic who would not take his insulin regularly and drank heavily once in a while. They were only married one year, according to Ester and she says she was working 12-hour days when her husband died on their living room floor. She says he had swallowed his tongue in a diabetic episode when alone. Ester relates a sequence of this story (nervous laughter):

> . . . well that was the end of that marriage . . . that was a tragedy. I gave up the condo since he died there and moved back home. If a woman doesn't have a proper economy she is compromised. That is what society does to people . . . it is part of the addiction. We treat women like a piece of shit really . . .

She says she returned to her aunt's home with her baby. Eventually, Ester mentions she met an Air Force man in a bar. She refers to him as "a shit kicking cowboy from Colorado." She indicates they got married and eventually relocated to the West Coast. She says she and her husband abused alcohol and became alcohol dependent over the years.

Ester describes hitting her bottom in 1980. She states this was her turning point when she says she tried to kill herself while being very drunk. She says she "bottomed-out" when her 13-year-old daughter had gone on a weekend overnighter with friends. She recalls that her husband was traveling because she says he was a "fly boy" for federal aviation. She describes being alone by herself. Ester says she remembers being very ill, and that she was bloated and her hair was falling out. She describes herself as being "just a mess." She says she lived in a cul-de-sac in the suburbs. Most of her neighbors were into partying so they drank and partied a lot. She indicates she was into hard whiskey at the time and turned Joplin on really loud. She says she would go out and sit on the flower ledge of her one story house with the music blasting loudly with a "bottle of wild turkey . . . and just drink the wild turkey and listen to the loud music." She indicates some of her neighbors were into it too and joined in others were bothered by the noise. She says she made a "spectacle of herself" by falling down in the ivy bushes. Ester describes how she would find herself blacking out while walking around in the neighborhood or blacking out on people's porches. She states at that time as she was:

> . . . just really a mess—that drugs and alcohol took me there . . .I had looked at myself in the mirror and saw a monster . . . oh, god! I can't do this anymore . . .

> I didn't even know who this person was. I can remember this because here I was this knock out dead, . . . gorgeous young women, I mean tall and thin. I come from part Native American background and I took more of those features when I was younger. . . . But somehow it all caught up, and I remember looking in the mirror and saying, 'oh, my god, I had lost me.' I had nothing, . . . I was dead, I was just a shell of a person. I had no soul, I was just dead. I hated this because I am a very feeling and caring person. I'm a very driven type A person and I had no drive left . . .

During that pivotal day, Ester says that two Jehovah's Witnesses came to her door. They had a copy of the Watchtower, according to Ester, she says they wanted to save her. Ester indicates she remembers the anger in her response to them:

> . . . the anger in me was unbelievable! All this anger of being abused, all the anger that had accumulated from all the bad luck and the abuse, life 101, people dying when they shouldn't have been dying, all that stuff! You know, the accumulation of all of it. When I slowed down enough to let it all catch up with me. I opened the door on these two people. They gasped when they saw me because I was red-eyed, bloated, hair messed up, stinking probably, just this monster met them at the door. And the minute they mentioned the word Jesus, I said, 'you know, you can tell your Jesus to go fuck himself . . . where the hell was he when I was being kicked down flights of stairs when I was a little girl?' Oh, god, I was angry at these people. . . . I chased them down the porch saying, 'where was your Jesus when I was a little girl?' . . . 'where was that son-of-a-

> bitch then?' . . . I was so pissed at God—I couldn't feel God—I couldn't feel Jesus, I couldn't feel anything! I hated God. You're a bastard –you don't give a shit about little girls. That is what was in my head.

Later in the day, Ester says she took her husband's German luger semi-automatic gun, and reloaded the bullets into the clip. She remembers taking a bottle of Wild turkey and sat at the kitchen table with a shot glass. She says she put the loaded clip on one side and on the right side of her she placed the Wild Turkey and a Thai stick. She describes making a contract with herself that when she was finished drinking and smoking she would load the gun and get out of there. She remembers thinking, "I wanted the hell out of here!" She then says she put the clip up into the gun, put the gun with her left hand to her left temple and pulled the trigger. Ester describes blacking out at that moment. She indicates she does not know why it didn't go off. Ester remembers not feeling anything at that moment:

> There was nothing in me that gave a shit. There was no feeling in me whatsoever. I was dead. This is what drugs and alcohol do to people when you bottom out to that degree. I have heard that story over and over since then. . . we become spiritless". . . alcohol is the most insidious damn situation on the planet. It definitely affects some people in a very interesting way. When I came out of that and I realized what I had done. I panicked. And then, I realized—oh, shit, I am in trouble. . . . somebody save me.

Ester says she does not remember the sequence in her story when the gun did not go off. She states she only remembers that she had placed the gun to her temple and pulled it.

She says she "was too drunk to do it right . . . if I had been less drunk I may have done it better and wouldn't be here now."

The very same day that she failed in her attempt to kill herself, according to Ester, she says she contacted Al-Anon, which is a twelve-step program for co-dependents. Two women came to her door within minutes after her call for help. Ester states this was the beginning of her 22 years of long-term abstinence from alcohol dependence/abuse. She describes this part of her recovery story:

> . . . I called the hotline number . . . two women like a couple of angels–beautiful blond older woman and a younger woman came to the door immediately. I mean, immediately! It was like they were right around the corner, which they were, at a meeting. They were meeting at a house right around the corner. I said I had just put a gun to my head and needed help. They hussled . . . It was the first indication that anybody gave a shit. You know, (Ester was choking down tears at this point in our conversation) and said "in fact, I am really tearing up because that was just like A.A. folks—they didn't need to show up. They didn't know what they would find. They didn't know if I would shoot them for godsake. They just showed up and it impressed the hell out of me! That was my first experience with A.A. and it was good because of the love.

After that first A.A. meeting, Ester never drank alcohol again.

Ester says she has maintained her recovery for 22 years due to her "tenacity of will" embedded in her membership and participation in A.A. She also insists that A.A. is the "greatest altruistic sobriety movements on the planet." Ester stresses that she loves A.A.,

its fellowship and the healing she has gained from being actively involved in her own recovery and the recovery of others. Ester asserts that she has had no relapses since her choice to become sober (abstinent). She says she spent her first few years of recovery attending meetings almost every day. The first five years of her sobriety she states she still lived with her alcoholic husband. Ester says she came home one day to find him with a strange woman hanging onto him. According to Ester, this part of her story very well have been a "relapse opportunity," but she says her choice to stay sober prevailed:

> . . . I had an Al-Anon sponsor because of my husband. I was a *double-winner,* . . . I was exposed to meeting, meetings, meetings! . . . I didn't have to work because my husband made enough money, so then I could recuperate. In my opinion it takes about five years to get that all out of your system. I was very fortunate. I made a commitment. The same tenacity of will that kept me going through the addiction is the same thing that kept me going through sobriety. . . .It was spiritual when the ladies showed up at my door. How could I not notice it right away? The contrast to my other life was too much. . . .My life was just wonderful after I sobered up. . . .Had I been left on my own I probably wouldn't have made it. My husband was very supportive, he didn't want to have anything to do with it [for himself] . . . He'd even come every birthday and take a cake. My biggest wish was that he'd get sober and we'd ride off in the sunset together for the rest of our lives. I wanted to be married to that man for the rest of my life. That was the love of my life, especially after all the shit I had gone through. He did not get sober . . . in fact, he flew off on one of his journeys and came back dead drunk

> with a blond on his arm . . . walked into our house with this blonde . . . She had just lost her husband, an alcoholic husband . . . both drunk off their asses. . . they walked into my house, our house, . . . they were sitting on the couch. I came home and here were these two people . . . they announced they wanted to be together . . .that was the end of my marriage. . . I was five years sober . . . I thought this can't possibly be happening. No build up or warning. The beauty of the program when it does kick in . . . it had thank god! See all that love that those A.A. folks showed me paid off at that moment. Because had I not had a sponsor, had I not been going to meetings, had I not forgotten that I was surrounded by sobriety, and all that 12-step work entails. You know, all that stuff . . . I was working on a very solid program. Had not one of those elements been in place, God only knows what I would have done. My first thought was to pick up the loaded shotgun and blow him away. The second thought immediately after that was, 'go call your sponsor.' . . . Sanity kicked in. I was trained to be sane in A.A. . . . Had he done that earlier in my sobriety I don't know what would have happened. I believe in timing it has to do with a lot of stuff . . . I did call my sponsor . . . we worked the same stuff as I did in my early sobriety. She shadowed me and I hung out at her house. I told him to get the hell out!

Ester asserts that she never turned back to her former alcohol abuse even after the very traumatic end of her marriage.

In addition to working the A.A. program daily, Ester says she has developed a deep sense of personal spirituality in her life. She states she practices the Bahai faith.

Prior to becoming sober Ester followed no particular religious and/or spiritual viewpoint. But, in A.A. she says she discovered spirituality and was able to fully connect with her own sense of a "Higher Power." Ester describes her awakening to spirituality:

> . . . they took me to an A.A. meeting . . . I don't remember a word, but I do remember all these signs up on the wall [such as] *First things first—Put God* . . . and, 'oh, god!' . . . G-O-D in big gold letters . . . I thought, 'oh, my god, I am in trouble!' . . . took me a long time to become comfortable with God. I didn't become Bahai until 1982. . . . My first loyalty is to the program for if it hadn't been for the program I wouldn't have recognized and become a Bahai . . . compassion kicked in . . .

Ester indicates that her program and her faith are her mainstays in her maintenance of long-term sobriety. She says she was even able to establish connection with her Native American heritage by learning about Native American spirituality. Ester states she now incorporates aspects of Native American spirituality and healing techniques into her daily life.

According to Ester, she says that "alcoholism [sic] is alcoholism [sic]" whether one is a woman or a man. However, she insists that women do tend to be more "sensitive . . . our chemistry is different" than men. Ester asserts that drinking alcohol and recovery from alcohol dependence and/or abuse are "literally a choices." She speaks of her healing work with others by saying:

> . . . in my work we give choice where no choice seems to exist . . . for me, and I can only speak for myself—I choose on a daily basis to stay sober . . . I don't

> worry about the past—I don't worry about the future. I just stay in my day compartment . . . I literally work this program on a daily basis. . . . because that is what got me sober and if it works don't fix it. So, I just get up in the morning and I ask God for my sobriety and my sanity. It's not good to be just sober, I want to be sane! Yet, I do all the rest of the prayers I do, but I follow that *Big Book*, every word in that *Big Book* is relevant to me in my recovery. And I am a recovered alcoholic . . .,[though] spiritually we are always going to be recovering. It's a two-pronged issue . . .

Ester says she has recovered physically from alcohol abuse, which she suggests takes about five years to be complete. In her work as a homeopathic healer, Ester says she holds the viewpoint that drugs and alcohol take approximately five years to fully exit the "fatty tissue" in the body. Full physical recovery, therefore, in Ester's opinion starts in the fifth year of sobriety (abstinence).

There are concerns for the woman, according to Ester, she says such as the societal stereotype of being a "whore," which is perpetrated on women who drink. Consequently, Ester insists that psychologically a woman suffers more through her treatment from others in society. She describes her own experience:

> . . . I think that women are impacted more on all levels . . . than men when they become alcoholics. Even if they are closet drinkers, there is such a stigma to being a woman alcoholic . . you wouldn't think of raping a drunk man . . . a woman is up for grabs the minute she loses control . . . there's that double standard in the drinking world. . . . part of culture [relates to] the religious aspects

> and societal aspects, [which] include . . . the prejudices towards the tolerance of women doing anything . . . considered sexually reckless . . . especially, if she has children . . .the guilt, the shame and the fear of all those things are so much more acute in a woman than in a man.

Ester says she centralizes women's recovery concerns and she indicates she wants to give service to others who are embroiled in alcohol dependence and/or abuse. She says she intends to work with newly recovering women alcoholics when she finishes her schooling. In fact, she indicates she has already been doing aspects of this work over the years, but she says she recently has become more focused in her work and service, especially toward preventing relapse in women who are in the early stages of recovery from alcohol and substance abuse.

Morgan's Narrative Interview

Morgan lives in a large city in the Interior of Alaska. Morgan is a 52-year-old bisexual woman who has lived in Alaska since 1977. She relocated to Alaska from the East Coast. She has worked in various professions over the years such as health care, education, and administration. She has more than 28 years in recovery from alcohol and substance dependence/abuse. She stopped using alcohol and drugs at the same time. Morgan is a gifted craftsperson and musician. She is dedicated to her recovery and her spiritual studies. She volunteers service to those in need of help who are suffering from the same addictions as she experienced in her adolescence and young adulthood.

Morgan and I met at a private location to conduct an hour interview. Our schedules were both busy, so we had to meet after work hours. Morgan was very open

and candid about her former alcohol and drug abusing days. She often laughed out loud as she described people in her life and situations connected with her alcohol and drug abuse. She also took the time to make sure I understood specialized terms she used when referencing either drug culture or A.A. culture. Morgan's interview was very informative as well as revealing in regard to her alcohol abuse and dramatic recovery.

Morgan's Story

Morgan says she was an "only child." She mentions that her father died of heart disease when she was twelve years old leaving her alone with a mother who was diagnosed as mentally ill. Morgan indicates that there was much alcoholism [sic] and mental illness on her mother's side of the family. She describes her racial and ethnic background is Caucasian—Jewish, both mother and father. She says she was raised on the East Coast as well as had completed her undergraduate degree near her birth home.

Morgan says she began drinking at the age of 12. She states that she would never forget the first time she got drunk:

> . . . I was at a barmitzvah of a friend of mine . . . there was one of those funny uncles who thought it was amusing to feed the kids alcohol . . . he kept pouring it in our glasses and poured enough in my glass that I got drunk . . . It was a wonderful experience! . . . I never felt so happy and . . . free in my life . . . a lot of alcoholics have this experience. You spend your life chasing that high . . . it felt so good.

Morgan states she continued to drink during her teenage years. She says she had a boyfriend in high school that she drank with often. According to Morgan, she maintains

they had friends who would watch out for them when they were drinking to make sure they both got home "in one piece." She says that she would come home "stinking drunk" and that her mother never really knew. Morgan asserts that she was an alcoholic by the time she turned 16 years of age. She says she became pregnant at that time, but chose to give up her daughter to adoption. Coincidentally, Morgan mentions she found out later that her adult daughter was also an alcoholic even though she had been raised in a family with no alcohol addiction problems:

> . . . I did not raise my daughter . . . she was put up for adoption when she was five days old. She was raised in a different family where there were no alcoholics or drug addicts, none of that . . . we each went our own way and found [A.A.] . . . I think we are such a test case for the genetic nature of alcoholism [sic].

In college during the 60s, Morgan says she discovered "drugs." She indicates she began smoking marijuana in addition to drinking alcohol. Later she says she added cocaine, speed, and psychedelics to her drug regimen. When Morgan got pregnant for the second time, she says she decided to raise her child.

Morgan indicates her teenage years revolved around "drinking" and indiscriminate sexual behavior. She describes an incident that occurred shortly after she had her first child:

> . . . a few months after I had gotten pregnant and given up my child . . . my uncle who was the closest male role model in my family . . . molested me. . . . at that moment what went through my mind was, 'if he thinks that I am a piece of trash, then, that's what I must be . . . nothing else matters and that was the end' . . .

> After that I drank whatever I could and I had sex with anybody I could. I discovered drugs a year and a half later in college and off I went into this huge downhill spiral for about nine years.

Morgan says she drank regardless whether she was able to obtain any drugs. She describes herself as a "maintenance alcoholic" since she maintains she was rarely ever "truly drunk," but had alcohol in her system all of the time. She states her drinking behavior included drinking every day throughout the day. Morgan says she was alcohol dependent, but she states not understanding this at the time. She describes her experience of drinking alcohol during that period in her life:

> . . . there is the binge drinker who is sober for lengths of time and then goes on big binges . . . there are people who are falling down drunk all of the time . . . and then, there are the maintenance drinkers, which I in large part was . . . I was never truly drunk, but I always had alcohol in my body. . . . and I was drunk, I mean I got drunk almost every night, but I drank throughout the day and if I didn't get drunk at night I still had a drink . . . I was never sober.

Near the end of Morgan's drinking and drug abusing days, she indicates that her drinking behavior and alcohol and drug intake had become problematical escalating to dangerous levels. She says she worked a job, but also attended school part-time and was raising her child. According to Morgan, she describes her daily routine as consisting of:

> . . . smoking a joint before I got out of bed . . . I would get up and have breakfast . . . put a couple of shots of blackberry brandy in each of my two cups of coffee. I would smoke another joint, then out the door to school or work . . . I would have a

> beer with my lunch . . . I would get high with the people I worked with during the day. I would come home at the end of the day and get drunk. . . . I was probably drinking about 10 to 12 drinks a day, smoking about 2 ounces a week of marijuana, and doing about 6 to 10 grams of coke a day at this point.

Morgan suggests that her addictive behavior led her to a "bottoming out" experience, which she says caused her to stop all addictive behavior.

Morgan states her experience of becoming clean and sober happened all at once. She mentions that she quit drinking alcohol and taking drugs due to a "pivotal experience," which she says occurred without any warning. She describes that she had been doing her usual drinking and drug using routine on a particular evening when she says she suddenly began to choke:

> . . . I had done a whole pile of cocaine and I think it just paralyzed my breathing system . . . I could not take a breath . . . I stood in front of the other stoned out people in the room making the hand gesture of 'I can't breathe' . . . they looked at me in their stupor and made no motion toward me whatsoever. . . . I had also been trying to eat a sandwich . . . I think it was the sandwich that was caught in my throat at the same time. I did the Heimlich maneuver on myself on a chair . . . I almost passed out . . . my heart began racing and pounding . . . I was finally able to explain to the person I was living with what had happened . . . he said, 'oh, you should use my inhaler" . . . so, I took a big hit of that and then my heart was really pounding . . . I was certainly having a panic attack once all this launched.

In her panic, Morgan says she made a promise to God that she would quit all alcohol and drugs if she made it through that evening. She stresses that she did survive this event and says she never drank or took drugs again. She insists that she takes her promises to God "very seriously," so, she says there never was any other choice but to become sober (abstinent) after nine years of alcohol and substance dependence/abuse.

Morgan indicates she just stopped "cold turkey" without any professional or chemical assistance. It was the mid-70s, which was shortly prior to the proliferation of 12-step programs and she says she did not realize that the symptoms she was having were connected to going through the detoxification process. She states she had daily panic attacks in the year after she quit as well as:

> . . . very bizarre things. I had these paranoid ideations . . . I couldn't eat a tomato because it had skin on it . . . I was afraid my breathing was going to stop again . . . I began having panic attacks almost constantly . . . I had all these bizarre physical responses to things that, in retrospect now, I understand was withdrawal. But, nobody identified it to me as that. I simply thought when this began I didn't associate the symptoms with the cessation of drinking. I just thought you stopped and it was over. It didn't dawn on me that it would have consequences . . . I would be up in the middle of the night with panic attacks . . . I was having paranoid ideations about [my boyfriend], which I knew in my conscious mind were totally fallacious . . . I was given valium, which I then got addicted to. It took me a year to back myself off of it.

Morgan says she spent two years afterwards going to therapists for her various symptoms. She mentions she realized many years later that her symptoms were typical for the detoxification of alcohol and drugs out of the body.

For the first 12 years of her sobriety (abstinence), she says she followed no actual program of recovery. She mentions simply practicing abstinence from alcohol and all drugs. She indicates she was not acquainted with A.A. or any other recovery philosophy at that point. One day while she was at work, according to Morgan, she says she was watching her favorite television soap opera where a character was a recovering alcoholic in an A.A. program. She speaks of hearing a voice in her mind suggesting that she too attend an A.A. meeting. Morgan says she attended a local meeting of A.A. the very next day. She indicates that her true recovery from alcohol and substance abuse did not fully take place until she began working the A.A. program 12 years after becoming sober. Prior to working the steps in the program, Morgan says she was in "denial" regarding the bad behaviors connected with her alcohol and drug abuse. She aptly describes this part of her recovery story:

> I heard that little voice inside my head saying, 'you should go to an AA meeting!' And I thought, I don't drink anymore it's been 12 years. 'But, you should go.' And I said, 'uhhhhh, okay, I guess it wouldn't hurt to check that out.' And I picked up the phone book and I found out where the [meeting] was . . . I found myself the next day at a meeting. Walked in the front door . . . didn't know why I was there. In fact, . . . one of the people who talked to me when I came in the door . . . I said, 'I haven't drank in 12 years and I have never been to one of these

> meetings. I don't know why I am here.' He said, 'insurance.' And, I found out that I basically hadn't been drinking, but I hadn't really done . . . actual recovery. . . . they call it white knuckle drunk . . . or dry drunk. And, I really thought that was the case for me . . . it was an extended period of time beforehand, and then, suddenly I was learning to identify the behaviors that were inappropriate and how to actually come to peace with it . . . if I drink again I know I am dead.

Morgan says she has been an avid A.A. and 12-Step program person for the past 16 years of her long-term maintenance of recovery from alcohol and substance dependence/abuse.

Morgan states she has also developed a deeper connection with her faith in God and her sense of spirituality over the years. She says she has explored Eastern and Native American philosophies as well as studying the spiritual precepts of her own religion. Morgan indicates has also studied metaphysics for many years and is able to apply the spiritual principles she has learned to her ongoing recovery. She describes the way that she works her recovery program as "reinforcing the positive messages of the program on a daily basis."

Morgan says she believes that essentially there is "no difference" in the physical, mental, and spiritual aspects of recovery for men and women. However, she insists that women's concerns "tend to different than men's" because women focus on "relationships." In addition, if an alcoholic woman with children seeks treatment or is forced into treatment by others, Morgan suggests the woman runs the risk of losing her children. She also maintains that women alcoholics tend to have co-dependent behavior

as well. Morgan says she worked for a short time period in an alcohol treatment center. She relates a few of her experiences during that time:

> . . . inevitably [women] have children that have been taken away from them. So, they are all upset about that. . . .I haven't met a woman alcoholic that wasn't an active co-dependent . . . even if they come out [of treatment] sober . . ., they go back into the same environment . . . they want to be with the same jerk they are with . . . they are perfectly willing to throw it all in the toilet for him . . . my favorite line that I hear from women [who continue to drink while] in the program and in [treatment] when they have their children taken away . . . they are all very contrite and say, 'I would do anything for my child!' . . . I always wanted to say, 'no you wouldn't! Stop drinking is what you need to do for your child.' . . . but, back [when I was abusing drugs and alcohol] I wasn't thinking about all that . . . I went from . . .never letting any of that around my son to having people dealing in my house . . . if I had been caught they would have taken my child too.

Morgan says that women's major concerns tend to be "relationships, co-dependency, and family issues." All three of these concerns, according to Morgan, have been important to her own recovery process. She says she works her program daily insisting that she can never go back to abusing alcohol or drugs because if she did she asserts she would be "dead."

Bobbi's Narrative Interview

Bobbi is a 58-year-old homosexual woman who lives in a city in the Interior of Alaska. She has resided in Alaska since 1991 after relocating from the U.S. West Coast.

She works in her home as a craftartist. She told me that she receives social security because of her "dual diagnosis" of having a mental illness and former alcohol and drug abuse. Bobbi has had more than 30 years of recovery from alcohol dependence/abuse. In the thirty years of her recovery from alcohol problems she has had two major relapses, but she insists that her definition of recovery has "evolved" over the years. She no longer believes in the A.A. philosophy stipulating that recovery from alcohol dependence and/or abuse means absolute, continuous abstinence. If she were to accept that viewpoint, she would have more than seven years of sobriety at this point in her life.

Bobbi and I met at a private location away from my office. She spent about 90 minutes telling her story of alcohol dependence/abuse. Bobbi smokes tobacco so we went outside several times during the interview so she could smoke. She volunteered to be a participant in my research after she realized that I was exploring various views of recovery from alcohol dependence and/or abuse. Bobbi's told her story with enthusiasm and humor. I learned much from her candid sharing of her life with alcohol abuse.

Bobbi's Story

Bobbi says that her parents were alcoholics who abandoned her when she was 2 ½ years old. She speaks of being raised by her "abusive" paternal grandmother and her step-grandfather. She describes being the middle child out of three children. Bobbi says that her brother passed away three years ago due to complications from kidney failure and diabetes and mentions that, "at his death he had 30 years of sobriety (abstinence)." According to Bobbi, she says her older sister is also in recovery.

Bobbi describes her racial and ethnic background as "I'm a mutt! . . .I have Caucasian, Enlgish and German on my father's side . . . Native American—Cherokee, Caucasian, and African American on my mother's side of the family." According to Bobbi, she says she was raised in the U.S. South in a rural area in the mountains. She describes growing up in "a religious environment, which wasn't spiritual at all." In addition, she mentions that her experience of being raised in her grandparents' home was "extremely abusive on every level." She recounts how she and her siblings were ritually sexually abuse by her step-grandfather. According Bobbi, she says her grandmother allowed the abuse to happen without interfering. Bobbi relates this memory of her childhood experience:

> . . . when I was 12 or 13 I thought well maybe . . . I should get the hell out of here and find [my mother] . . . My step-father was sexually abusing me all the time . . . my grandmother was mentally abusing us too . . . she told me that my mom was Satan and that I was Satan's child . . . I was meant to be sacrificed . . . that was my purpose in life, they had to do this to me . . . when I was 9 or 10 I was big enough and mean enough that they wouldn't drag me to church . . . my step-grandfather was a deacon in the church and was sexually abusing my brother and sister too . . . I had gonorrhea for so long that my eyes were affected, my hearing was almost shot . . . I was a wreck!

Bobbi stresses that she left her grandparents home when she was 14 to find her mother. According Bobbi, she says her mother was "working in a factory on the East Coast . . . she had left home to find work up North and never came back for me . . ." She maintains

that her mother was in recovery from alcohol dependence/abuse when Bobbi found her. Bobbi mentions that she lived with her mother and step-father during her adolescence. According to Bobbi, she says her stepfather drank even though her mother had quit drinking. Bobbi recounts a story about how he allowed her to drink alcohol in the home when she was a teenager. According to Bobbi she began drinking alcohol when she was 10 years old. Bobbi says that her mother called her "my little alcoholic . . . and dragged me along to A.A. meetings."

In recounting her life before she became sober, Bobbi says she "didn't really feel like I belonged anywhere . . . I was really desperate to fit in with my peers." She says she began drinking because it "was soothing" to her emotionally. However, according to Bobbi, she makes it clear that drinking alcohol ". . . turned into a way to connect with . . . peers." She says "a lot of my drinking and using at that time was to get around my own social anxiety." Bobbi also mentions "I didn't really feel like I belonged anywhere."

According to Bobbi, she mentions she attended A.A. meetings while she continued to drink. She recounts a story of falling love and wanting to make a change:

> . . . I fell in love with a woman, and, of course, she was an alcoholic. I met her at an A.A. meeting. For a year and a half I would go to meetings drunk and they would give out 'desire chips.' If you came in drunk wanted to be sober (abstinent). After a while they began breaking the chips in half telling me I had half a desire (laughing).

The relationship with the woman blossomed, according to Bobbi. She says they stayed together for many years until her partner died of cancer. She states they both achieved

complete abstinence from alcohol during their relationship. Bobbi indicates that A.A. continued to play a major role in her recovery at that time. She spoke of having flashbacks to her childhood abuse after five years of abstinence from alcohol:

> . . . at five years sober (abstinent) I had what they call psychiatric amnesia. I had taken all the abuse and didn't remember most of it. It was murky . . . I knew some of it had happened, but had buried most of it. And it all came flooding back at five years and that was my introduction into therapy and getting help. That was the first time someone suggested that I take psychiatric meds . . . and I was scared to death because I was clean and sober (abstinent). The people in A.A. said, 'don't do that.'

Bobbi recalls having a "pattern of suicide" since she was nine years old. She says she finally quit that pattern in her mid-thirties after her partner died of cancer. At this stage in her recovery, Bobbi declares she has a "huge focus on Native American spiritual philosophy." She says she expresses her spirituality through her art. When asked if she had any advice for women who are alcohol dependent she mentions:

> . . . power differentials are still so pervasive in this society . . . underneath all this experience and powerlessness, the fact that I was a woman . . . as I became more self aware . . . I began using that as a badge. It became a shield . . . that was useful for a while, then . . . if worked against my recovery . . .

Bobbi insists that her "whole world view had to change" when she stopped abusing alcohol. She says she didn't have "any sense of myself." According to Bobbi, she describes becoming very spiritually aware and eventually letting go of dogmatic A.A.

philosophy. She says that recovery is an "evolutionary process . . . I would not be here if it hadn't been for A.A. . . . but now, I say that any modality I had chosen at the time. . . would have been effective. Bobbi stresses that she has fully "recovered" from alcohol dependence/abuse.

Summary & Conclusion of Narrative Interviews

The nine co-researcher narrative interviews represent the lived experience and lived meaning of women in Alaska maintaining long-term recovery from alcohol dependence and/or abuse. As each woman told her authentic story of alcohol problems and recovery a new layer of meaning regarding recovery was being co-constructed in the moment. According to Shotter (1991), a person "re-authors" (p. 105) his or her identity in the process of sharing personal stories in conversation. Stories of self perform many functions such as psychological, social, mystical-religious, and cosmological-philosophical functions (Atkinson, 1998, pp. 9-10). We are, after all, narrating beings because storytelling is part of our collective history (Fisher, 1989, p. 57).

CHAPTER IV

Narrative Analysis

Narrative analysis involves interpreting thematic structures derived from people's authentic stories and constructing a cohesive distillation of shared meaning amongst the various co-researchers' lived experience and lived meaning. According to Kvale (1996), the narrative analysis report is the "final story told by the researcher to an audience" (p. 184). In contrast, the interview descriptions are told solely in each interviewee's voice. According to Wolcott (2001), the notion of "authorial voice" (p. 20) is a central concern within the representation of qualitative research. He contrasts the dominant view of research reporting, which is quantitative in orientation, with differences in qualitative approaches such as stating:

> . . . approaches that focus on the life of one or a few individuals, the problem is compounded when informants are capable of telling their stories themselves, raising doubts about how or whether we should make our presence known. In quantitatively oriented approaches, and among the more self-consciously 'scientific' qualitative types, researchers typically desert their subjects at the last minute, leaving folks and findings to fend for themselves, seemingly untainted by human hands and most certainly untouched by human hearts. One of the opportunities—and challenges—posed by qualitative approaches is to treat fellow humans as people rather than as objects of study, to regard ourselves as humans who conduct research *among* rather than *on* them. (p. 20)

Therefore, in narrative analysis, a new voice, the co-constructed voice of the researcher, emerges as the synthesizing agent and interpreter of "overlappings among the meanings" (Kvale, 1996, p. 185) in co-researchers' stories. These reconstituted interpretations are, thereby, contextually verified back to the original lived experiences and lived meanings as described in the interviewees stories for thematic cohesiveness.

Ettling (1998) suggests the use of an additional layer of analysis that requires the researcher to attune to "three modes of intention" (p. 178) while listening and attending to the data in the process of final interpretation. She refers to this technique as "intuitive analysis" (p. 178). Ettling's recommendations for in-depth intuitive analysis include:

> (a) "listening for [the researcher's] emotional reaction to the interview while in a [relaxed or] meditative state, followed by a form of creative expression to integrate and conclude the experience; (b) listening for the emotional tone of the interviewee's voice and words; and (c) listening for content to attend to recurring words and themes . . . listening and reading . . . bearing witness to what was spoken. (p. 178)

This intentional layer of analytic emotional attunement by the researcher toward the voices of the co-researchers is considered by some researchers to be a "transpersonal" (Braud & Anderson, 1998) perspective. However, this approach is closely aligned with other strategies in qualitative research methods, especially, as in the use of "openness and emotion" in narrative interview technique (Kvale, 1996, p. 85). A transpersonal view of scientific inquiry suggests "research is complemented by what is missing in . . . conventional paradigms" (Braud & Anderson, 1998, p. 240). In my own research with

women who have recovered from alcohol dependence and/or abuse, I wanted to address the sensitive nature of the co-researcher's deep felt emotions regarding their lived experience with alcohol problems. I purposefully tuned into the nuances of emotional expression shared through nonverbal communication and their actual words during their storytelling. In addition, I paid close attention to my own reactions to their emotional sharing during the interviews. The descriptive consistencies noted in the process of distilling shared meaning or themes from the interviewees' narratives comes as much from my own reactions to my interpretation of the stories as from the interviewees apparent emotional self expressions. In this sense, there is a co-constructed quality to the interpreted thematic understandings derived from the interview data—which is an implicit intersubjectivity of ongoing reciprocal reality and identity construction between researcher and co-researcher. The narrative analysis understood from this viewpoint speaks to the profound complexity of human meaning-making in everyday occurrences told as stories as well as in the interpretations of conversations between researcher and co-researchers.

Summary of Pilot Study: Readiness to Change Health Behavior

As part of my research, I chose to study health behavior models (Figures 2.1-2.3) in order to understand the process one moves through in changing addictive behavior to healthy behavior. Four women who were in various stages of recovery from alcohol dependence and/or abuse were interviewed to explore the concept of *readiness* to make a health behavior change. According to the Transtheoretical Model and Stages of Change (DiClemente & Hughes, 1990; DiClemente & Prochaska, 1998; Prochaska, 1984;

Prochaska and DiClemente, 1983; Prochaska, DiClemente, & Norcross, 1992; Prochaska, Norcross, & DiClemente, 2002; Prochaska, Redding, & Evers, 1997) people tend to move through definite stages of development in the process of changing health behaviors. In order to understand how people change their health behavior in regard to addiction, a pilot study was designed to explore the process of successful health behavior change.

Four emergent themes (Richey, 2002, unpublished pilot study) were distilled from the interview data in regard to readiness to change health behavior: (a) a deepening awareness of family alcohol behavior, (b) struggle to maintain denial of life problems while everything in one's world falls apart, (c) dramatic event taking place while intoxicated, often a near death experience, and resultant transcendent (spiritual) experience or intervention, and finally, (d) fear of relapse or loss of control. The four themes were integrated with the Transtheoretical Model and Stages of Change (Figure 2.1), the Theory of Reasoned Action and Planned Behavior (Figure 2.2) and views regarding self-efficacy (Figure 2.3) and social support. It was found that self-efficacy and social support tended to play stronger roles in a woman's recovery process once it had begun, but tended not to penetrate a woman's denial in the precontemplative stage of change. Often a transcendent experience or period in the life acted as a bridge for a woman to move from precontemplation to contemplation. If the experience was intense enough the sequential stages of contemplation, planning, and action, occurred simultaneously. Integral aspects of the Theory of Reasoned Action and Planned Behavior such as "perceived behavioral control" and "attitude toward behavior" (Ajzen, 1991, 1996, 2001; Ajzen & Fishbein, 1980, 2000; Fishbein & Ajzen, 1975) tended to

make a noticeable shift when the woman was in the contemplation and planning stages. The thematic interpretations from the pilot study played a significant role in my design of a more in-depth study of women living in Alaska in long-term recovery from alcohol dependence and/or abuse in which identity construction would be centralized.

Women in Alaska: Modeling the Social Construction of the Emergent Self

In the process of conducting this research regarding the maintenance of long-term recovery from alcohol dependence and/or abuse in Alaskan women, I was also exploring issues of identity construction through the notions of self-narration (Gergen, 1991, 1994a, 1999, 2001; Gergen & Gergen, 1993), the discursive self (Harre, 1983, 1989, 2000, 2002b; Harre & Gillett, 1994), the social construction of illness (Lorber, 1997) and narrative therapy (McLeod, 1997). The research study for my master's thesis explored a person's co-constructed self-perceptions in identity construction within a therapeutic interaction (Richey, 2001). A central theoretical viewpoint in this research on identity was the Theory of the Social Construction of Reality (Berger & Luckmann, 1967) and Constructionism (Crotty, 1998). My research for this study regarding maintenance of long-term recovery from alcohol dependence and/or abuse was investigated with an underlying research question regarding how women actually construct a healthy self-identity. Because I already had been studying the co-construction of self through my previous research reading and inquiry, I wanted to apply this line of research toward a practical goal—understanding women's process of identity construction in the maintenance of long-term recovery from alcohol dependence and/or abuse.

I designed and implemented the research interviews while concepts of the social construction of self were loosely formulated in my mind. During the process of my post-graduate comprehensive examinations, I was asked by one of my committee members to construct a health communication model. The focus of the model was purposefully left open so I could apply my model to my own work with recovery from alcohol problems. I had no previous thought about constructing a model for my research on recovery, but this seemed like an appropriate direction to go, which would allow me to include my ideas about the social construction of identity with other researchers' studies on identity. Therefore, the process of constructing the health communication model began in the midst of conducting interviews. In fact, I had interviewed six of my co-researchers prior to the initial construction of the model for the examination.

The first prototype of the model was a Venn diagram I had acquired in one of my undergraduate communication courses. The instructor used a Venn diagram using the concepts of physicality, sociality, and symbolicity as integral aspects of the phenomenology of the self. The overlapping circles of the Venn diagram had always intrigued me because they intersected to create an emergent new construct out of the three individual circles. In the process of teaching an undergraduate course regarding human communication theory, I used the Venn diagram with the three areas of self I had learned in my previous course. When I earnestly began to think about what a health communication model might look like, I immediately thought about the Venn diagram of the phenomenology of self. I wanted to model the construction of self utilizing the intersecting circular style of a Venn diagram.

In my studies regarding the social construction of self identity, self narration, and narrative therapy, the importance of the social aspect of our identity as understood through personal relationships and cultural interactions is stressed. First, I placed the self in one of the circles, relationships in another circle, and intersubjectivity in the third circle. I wanted to show that we co-construct our self-identity in a social environment. However, I had to cogitate on what was actually represented in the middle where the three circles overlapped. At this point in the model's construction, I was still trying to give intersubjectivity its own place in the circles. It had not occurred to me to interject intersubjectivity on a different plane than the three circles, passing in and through all the circles. Also, during the initial process of constructing this model I had frequent conversations about the model with the chair of my dissertation committee. In our conversations, we mutually agreed that intersubjectivity should be a central aspect of this model regarding the social construction of the self. Thus, we decided the concept of intersubjectivity should be removed from the circles placing it in the center of the Venn diagram or in a different circle altogether. The evolution of the model's construct for intersubjectivity then was applied as a circle slicing through the other circles at their juncture points representing the emergent quality of intersubjective communication. The concept of the cultural self was applied to the third circle at this point in its evolution. In the first prototype of the model, the notion of culture had been placed in a larger encompassing circle in the model along with a larger circle representing the physical environment. Now, the model was complete in conceptualization, three intersecting circles: the experiential self, the relational self, and the cultural self with intersubjectivity

slicing through all aspects of self, which are embedded in a sociocultural and physical environment. The center of the Venn diagram was renamed the emergent self to address the concept of continuous site of self construction as a moment by moment emergent process. The model itself was a co-construction between other researchers' ideas on the construction of self, my own ideas, and the input and feedback of my dissertation chair. This health communication model deserves a central place in the analysis of health behavior because it is through intersubjective sociocultural interaction we are able to construct our identity either by maintaining a problematical view of self or by changing toward a better version of our existing self.

Constructionism, Communication, & Health Behavior Change

A person's self-concept and self-efficacy are central to treatment strategies for addiction such as problems with alcohol, nicotine, illicit drugs, prescription drugs, unhealthy eating behavior. Although, how one conceptualizes the self in the development of positive health behaviors is not an easy process to understand. This chapter posits a model for an emergent process of socially constructed aspects of self within a constitutive framework of intersubjectivity. The notion of intersubjective interpretations connects one's lived experience with one's networks of social relationships and one's existing cultural perspectives or standpoints. Or as Deetz (1982) puts it "the subjective is the intersubjective." A model of the emergent self is offered here as a conceptualizing of the foundational process of social self-construction, wherein, the development of the addicted self and one's restructuring as a recovered self are contextually embedded in the lifeworld. As a matter of course, any contextualization of

self can be explored within the choice framework of the on-going creation of the emergent self.

Traditional models of alcohol dependence and/or abuse often focus on concepts of the disease model (Jellinek, 1960) rather than centralizing the dichotomous lived experience between the addicted person and the recovered person. In the rhetoric of addiction framed as a disease, the substance abuse addicted or alcohol addicted person is depicted as genetically susceptible to its development, victimized within its development, and in recovery, perpetually one drink away from a full relapse (A.A.,1976; Denzin, 1987a, 1987b; Jellinek, 1960; Lewis, Dana, & Blevins, 2002; Miller, 1986; Miller & Hester, 1989; Marlatt, 1998; Van Wormer, 1995). Alcohol addiction treatment viewpoints vary in focus from an admonition to total abstinence, as found in the disease model approach of Alcoholics Anonymous (A.A.), to a view of controlled drinking, as found in the harm reduction approach (Marlatt, 1998). Current trends in philosophy for the treatment of alcohol dependence and/or abuse involve a multi-modal approach, which combine biopsychosocial aspects of the addictive process and healthcare delivery for effective recovery (Lewis et al., 2002; Van der Walde, Urgenson, Weltz, & Hanna, 2002). The biopsychosocial perspective appears to be a more holistic approach to healthcare treatment, since suggested within its organization is the notion that the person is a product of three interactive human systems—biological, psychological, and social. The addition of a communication perspective, however, extends the current biopsychosocial trend in health behavior studies to an understanding that centralizes the person as a composite individuation of his or her lived experience; social experience, and

cultural experience. This emergent process of self is in a perpetual state of becoming and is contextually formed within an intersubjective framework of communication. Another way of stating this is that communication is fundamental to the developmental process of the emergent self in that it is constitutive of the self.

A Communication Model: The Social Construction of the Emergent Self

The on-going, interactive human social process of communication occurs at the intersections between one's experience of self, one's social interactions, and one's situated cultural identity. The premise of this process suggests that becoming a recovered *self* emerges contextually, over time, within an ongoing sociocultural environment through one's intersubjective interpretive framework. The self here is conceived as a social construction (Deetz, 1982; Edwards, 1997; Gergen, 1991, 1994a, 1999, 2001; Gergen & Gergen, 1993; Harre, 1983, 1989, 2000, 2002b; Harre & Gillett, 1994; Lorber, 1997; McLeod, 1997; McNamee & Gergen, 1999). The model (Figure 4.1) is comprised of three interwoven systems of self, which are embedded in a physical and sociocultural matrix: (a) the *experiential or existential self*, (b) the *relational self*, and (c) the *cultural self*. One's personal experience of embodiment and capacity for the construction of personality, symbolicity, sociality, and the ability to act on choices constitute the *experiential self*—a state of being. The second system of self, the *relational self* (Gergen, 1991, 1999; Wood, 2000), represents how we see ourselves enmeshed in our various personal relationships. The third system of self, the *cultural self*, represents knowledge of self in the context of one's sociocultural perspectives or standpoints (Hartsock, 1997a, 1997b; Kramarae, 1981, 1996; Orbe, 1998; Stoetzler &Yuval-Davis, 2002; Wood,

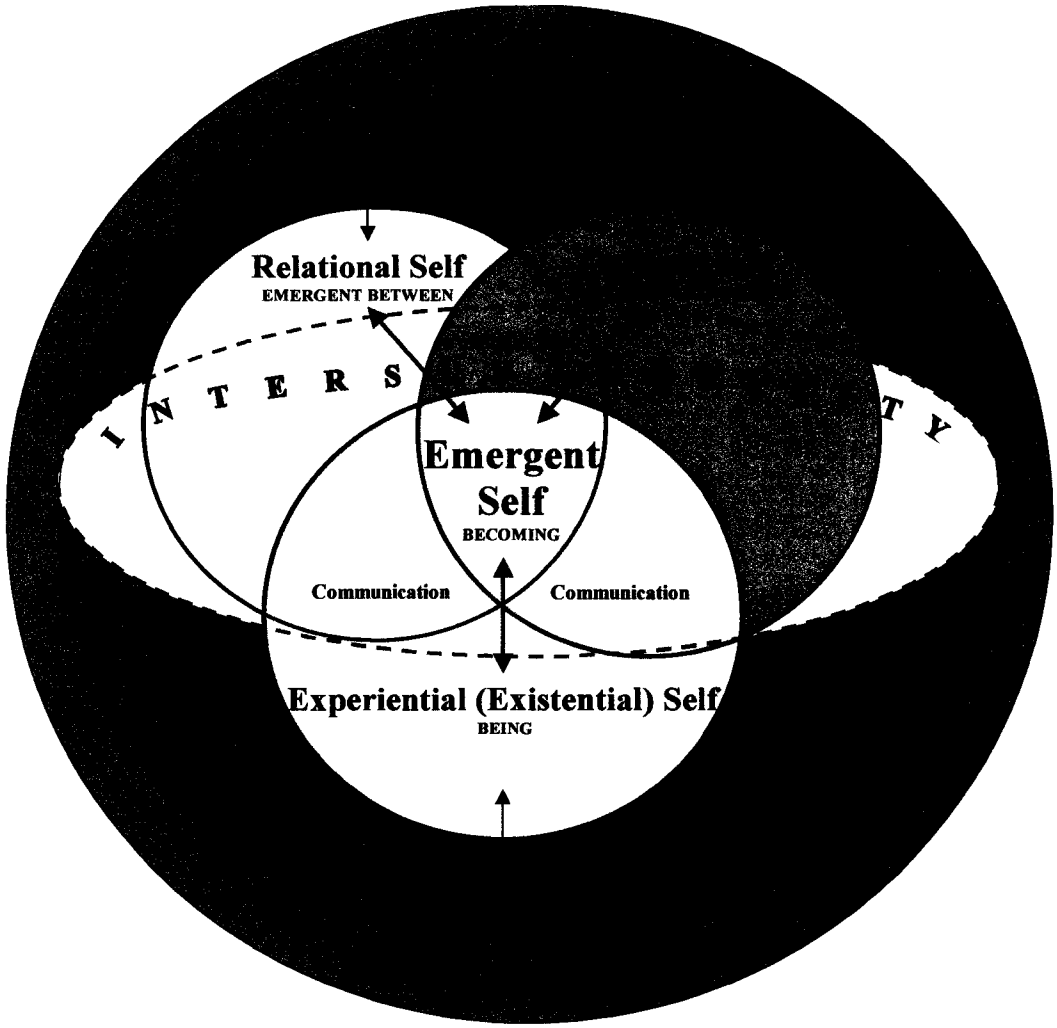


Figure 4.1. Emergent Self: Modeling the Social Construction of Self

1996c), which include contexts such as gender, race, ethnicity, age, sexuality, ability, and status. The overlapping or interconnectedness of the three systems of self creates a space at the center for an ongoing emergence of the self in the moment or in the *now* of that lived moment, which can be considered as being in a state of continuous *becoming*. This point of focusing on the *now* makes much more sense when framed in a health behavior perspective because the present moment is the only place where choice and action can be enacted for potential positive change. The communication occurring at all conjunctures within the system of the emergent self as well as from self to sociocultural others is the process by which humans share intersubjective meaning and create lived realities. Intersubjectivity pervades the whole human interactive system integrating aspects of the intersectionality of the three main aspects of self. Thus, the role of communication is the glue that holds the symbolic interaction system in motion and is essential to its functioning. A human system without it is inconceivable.

The Model's Theoretical Underpinnings: The Social Construction of Reality

The Theory of the Social Construction of Reality is foundational to the processes described in the Emergent Self Model (Alasuutari, 1997; Berger & Luckmann, 1966; Bradley & Morss, 2002; Burr, 1995; Crotty, 1998; Gergen, 1994a, 1994b, 1999, 2001; Harre, 1989, 2000, 2002b, 2002c; Harre & Gillett, 1994; Pearce, 1995; Shotter, 1991, 1993; Shotter & Lannamann, 2002). In the first part of the 20th century, George Herbert Mead, a professor of social psychology at the University of Chicago, began an academic dialogue regarding a social construal of the self. He referred to a person as a "social self" (Mead, 1934, 1968, 1982). Mead suggested that in the process of perception a person

"addresses himself [*sic*] and thus becomes an object to himself . . . The identification takes place in the social process out of which mind arises" (Mead, 1982, p. 187). Mead's notion of the self as a social entity hints at an emergent process of self in that a person is involved in social interaction "becomes a self . . . who organizes his [*sic*] response by the tendencies on the part of others to respond to his act" (Mead, 1968, p. 57). Berger & Luckmann (1966) extended Mead's conversation regarding the social creation of self in their seminal work, *The Social Construction of Reality: A Treatise in the Sociology of Knowledge*, in which they state:

> Identity is . . . a key element of subjective reality, and . . . stands in a dialectical relationship with society. Social processes form identity. Once crystallized, it is maintained, modified, or even reshaped by social relations. The social processes involved in both the formation and the maintenance of identity are determined by the social structure. Conversely, the identities produced by the interplay of organism, individual consciousness and social structure react upon the given social structure, maintaining it, modifying it, or even reshaping it. Societies have histories in the course of which specific identities emerge; these histories are, however, made by men [*sic*] with specific identities. (p. 173)

A reciprocal process of social and personal creation and action intrinsically related to identity formation is a key concept in social constructionism. Gergen (1999) refers to the process of reality creation as a "communal construction" (p. 33), which suggests four underlying assumptions inherent in its structure: (a) "for any state of affairs a potentially unlimited number of descriptions and explanations is possible, (b) our models of

description, explanation, and/or representation are derived from relationship . . . meanings are born of coordinations among persons – agreements, negotiations . . . from this standpoint, relationships stand prior to all that is intelligible, (c) as we describe, explain, or otherwise represent, so we do fashion our future . . . as our practices of language are bound within relationships, so are relationships bound within broader patterns of practice – rituals, traditions, 'forms of life' . . . In a broad sense, language is a major ingredient of our worlds of action; it constitutes social life itself, and (d) reflection on our forms of understanding is vital to our future well-being (pp. 47-49).

Gergen centralizes the notion of relationships as being primary to all human development. The study of human meaning originates in "human relationship . . . it is not the individual who preexists the relationship and initiates the process of communication, but the conventions of relationship that enable understandings to be achieved" (Gergen, 1994, p. 263). In this sense, a process of the emergent self was conceived as a template to understanding how the convergence of society, culture, and the individual create the self and how the self continuously recreates identity through interpretation in interaction with sociocultural others.

Social and human researchers have eloquently stated the case for relationship and social constructionism as the premise for human reality creation and maintenance (Berger & Luckmann, 1966; Gergen, 1994a, 1994b, 1999, 2001; Schutz & Luckmann, 1973; Shotter, 1991, 1993; Shotter & Lannamann, 2002). The theoretical perspective of social constructionism locates human communication in *relationship* as the process by which human meaning is established, maintained, and changed over time. Human

communication is an intersubjective process. Schutz & Luckmann (1973) posit that human realities are constituted "in the world of everyday life [in] a common, communicative, surrounding world . . . ,[which] from the outset, my life-world [and the life-world of others] are not . . . private worlds, but, rather, are intersubjective; the fundamental structure of . . . [human] reality is that it is shared by us" (p. 4). The creation of shared human intersubjective meaning originating in human relationships is, thus, the central process in identity formation, maintenance, and change. Again, Deetz (1982) goes so far as to say in regard to Husserl's original idea that "subjectivity is intersubjectivity" (p. 8).

Co-Construction of Identity

Identity creation or the development of self-identity is a co-constructed process, which emerges through human communication in a relational and social matrix. Interpersonal interaction is the arena where "reality construction, confirmation, and transformation [originate, as well as, it] . . . has a special residual capacity to support the individual and maintain identity and meaning" (Deetz, 1982, p. 2). Harré (1983) suggests that one's self-identity is temporally located within an ongoing "autobiography" (p. 31) and that one's stories of self are situated in a social environment. He continues his discussion of self-identity creation by stating, ". . . personal identity depends upon a socially enforced theory of self by which a human being conceives a continuous coordination of point of view and point of action within the general spatio-temporal system of material beings including other people" (p. 41). Harré's notion of an ongoing autobiography corresponds to a continuous formulation of an emergent self, which is

constituted in relational interaction. According to Carbaugh (1996), the emergent self "is not a given in nature, but is a consequence of discursive and interactive life" (p. 6). Gergen (1994) frames relational interaction as constitutive to people's formulations of reality:

> The terms and forms by which we achieve understanding of the world and ourselves are social artifacts, products of *historically and culturally situated interchanges* [italics added] among people. For constructionists, descriptions and explanations are neither driven by the world as it is, nor are they the inexorable outcome of genetic or structural propensities within the individual. Rather, they are the result of human coordination and action. . . . to achieve intelligibility is to participate in a reiterative pattern of relationship, or if sufficiently extended, a tradition. It is only by virtue of sustaining some form of past relationship that we can make sense at all. (p. 49)

Jacoby and Ochs (1995) ground identity formation in co-constructive social interaction by suggesting that there is an "interactional basis of the human construction of meaning, context, activity, and identity" (p. 175). A co-constructionist approach to human reality and the development of identity, therefore, relies on an intersubjective, dynamic process of meaning-making. Self-identity, conceptualized in a co-constructive interpretive framework, suggests that any conceptualization of self cannot be separated from relational contexts.

Unpacking Aspects of the Emergent Self Model

The Model of the Social Construction of the Emergent Self (figure 3.1) is depicted in part as concentric circles representing specific human systems embedded within the physical world. The world of others—sociocultural others, is a continuum of co-cultural others (including cultural insiders and cultural outsiders). The generic model graphically represents the process of social construction regarding how each person is situated in a physical and social world. Eisenberg (2001) refers to the material and social external world of a person as the "surround" (p. 543). His perspective of the surround includes categories of human activity such as spirituality, economics, cultural values, societal rules, interpersonal values and behavior, and "biological . . . patterns that shape human development" (p. 543). The concentric circle labeled as *sociocultural others* in the emergent self model implies a similar conceptualization of the outer world as the surround in Eisenberg's model of the "Identity Process" (p. 543).

Intersubjectivity, which pervades the whole human interactive system, is shown as an additional plane permeating all sociocultural activity and human meaning. A specific context of self interpretation can be overlaid onto the model, such as alcohol or substance abuse, which would function within the emergent self-system revealing the constitutive, co-constructive processes established within that context through personal, social, and cultural experiential systems of self (figure 1.2). A general discussion of the components of the systems of the emergent self must be explicated first before an actual health behavior context is introduced for discussion.

First System of the Emergent Self: The Experiential Self as Embodiment

The originating place of self is one's experience of being in the world. We are all born "into a social world with pre-existing languages, relationships, social networks, and culturally prescribed patterns of behavior" (Eisenberg, 2001, p. 543). In the emergent self model the system of self is referred to as the *experiential or existential self.* The following concepts are subsumed within the experiential self: (a) Embodiment—one's physicality and consciousness in and of the world, (b)Agency—one's ability to choose (interpret) and act in the world, (c) Symbolicity—capacity for symbolic interaction; language and nonverbal communication, (d) Personality—capacity for the development of personal affect and behavior over time, and (e) Sociality—capacity for relating to others. These aspects of the experiential self are potentialities developed experientially over time tempered by the unique quality of one's innate and ongoing physical and conscious abilities.

Traditional concepts of a person according to Western belief systems suggest, in a Cartesian framework, that the sensory body and consciousness are somehow separate forms. Mellor and Shilling (1997) state in their discussion of the "sensory body . . . that people's knowledge of themselves, others, and the world around them are . . . shaped by their senses . . . humans are not disembodied rationalist beings, but acquire information through their bodies" (p. 5). Lakoff and Johnson (1999), who have thoroughly analyzed a new philosophy of embodiment, support the later view of consciousness as an aspect of embodiment since human beings "conceptualize only through the body . . . the mind is not separate from or independent of the body" (p. 555). In this sense, individual

consciousness is understood as a part of a person's synergistic, experiential knowledge of embodiment.

The concept of agency is subsumed within the experiential self as one's ability to exercise volition and initiate action in the world. The theoretical notion of agency is an integral aspect of symbolic interactionism (Mead, 1932, 1968). In this regard, people are active choosers who make decisions and take action based upon personal intersubjective interpretations of their external world and interactions with others (Lal, 1995, p. 422). According to Bandura (2001), the notion of agency "refers to acts done intentionally" (p. 6). Bandura's concept of human agency involves intentionality, forethought, self-reactiveness, and self-reflectiveness [reflexivity] (pp. 4-11). Self-regulation and self-efficacy, which are important aspects of health behavior change, are subsumed within Bandura's perspective of personal agency and the human ability to practice self-reflectivity [sic, reflexivity] (p. 10). Intentionality, as part of the notion of human agency, renders moot the objectivism versus subjectivism debate because "what [it] . . . brings to the fore is interaction between subject and object. . . . It is in and out of this interplay that meaning is born" (Crotty, 1998, p. 45). As volitional agents, we create, maintain, and transform our realities and our selves in communicative, interpretive interaction. A capacity for symbolicity, personality, and sociality are aspects of the experiential self as well. These human potentialities develop over time through experience within a sociocultural environment.

Second System of the Emergent Self: The Relational Self

The *relational self* is the second main component of this system model of self. The relationships referenced in the relational self are primarily personal relationships such as experienced in family relationships, intimate relationships, friendships, and co-worker relationships. However, a person can develop interpretive pseudo-relationships with fictitious people, such as characters in books and movies or with real public personalities. A conceptualization of the relational self encompasses the notion that every personal relationship (distinct from uneventful, casual, or one-time encounters with others) with another human being is a unique joining together of two separate entities. The other person, in regard to the self, metaphorically creates a composite interpretive reflection distinct to that particular relationship. As a result, the existential self is redefined and renegotiated within each separate relationship, becoming a self—saturated with other selves (Gergen, 1991). Relational culture is a term used for this aspect of relationship and is described as "an extensive set of definitions, values, and rules which comprise a unique-to-the-relationship world order (Wood, 1996a, p. 13). Wood explains that the self in relationship "becomes a substantially different self than the one existing prior to the relationship" (p. 14). Duck (1994) extends this notion in *Meaningful Relationships: Talking, Sense, and Relating*, when he states "relationship brings together two previously independent beings and, by connecting them, creates something new from their sharing—something that presumably feeds back into each individual and affects the ways in which each thinks about [self and] the other in the future" (p. 17). The relational

self, therefore, is that dimension of self-definition that evolves and shifts through constant interpretation in regard to each personal relationship experienced.

The idea of the emergent "between" was initiated into the relational dialogue in an attempt to describe what was happening in the interactive space between people in relationship (Buber, 1970; Josselson, 1996). Josselson (1996) explicates this *between* as the "emergent we" in her discussion regarding mutuality and relational resonance:

> Related to, but not identical with, companionship is the emergent *we*. Here experience is enriched simply because it occurs in tandem. We feel empowered, larger than self, participate in something that could not have been created alone. . . . and in these comings-together, we know (together) with deep conviction that whatever it was that we made happen was not because of you or because of me, but because of *us*. (p. 159)

The concept of the *emergent we* implies an active, intersubjective process of relational mutuality and bonding. This aspect of relationship is co-constructed in interaction and in a people's responses to each other. As a consequence of relationship, a person's interpretation of self is in constant reconstructive motion—part as reaction to the distinct relational other, but also as a synergistic construction of new vistas of self-expression, self-creativity, and self-knowledge (either toward positive or negative constructions of the relational self). The relational self, framed in this sense, is analogous to a chemical reaction of two or more substances—systematically and constitutively transforming self through layers of interpreted representations of relationship within the alembic of social interaction.

Third System of the Emergent Self: The Cultural Self

Human beings are culturally embedded beings, who are born and raised in cultural settings. Culture, to its members, is transparent; we tend not to notice it unless we interact with people from other cultural or co-cultural systems. The third system of the emergent self, the *cultural self*, depicts an aspect of self-identity, which is nurtured, shaped, and influenced by a society's normative values, social practices, and symbolic interaction. Wood (2000) defines culture as "composed of intricately interconnected structures and practices that individually and collectively sustain a particular social order" (p. 104). Geertz (1973) refers to a particular conceptualization of culture as:

> essentially a semiotic one. . . . man [sic] is an animal suspended in webs of significance he [sic] himself [sic] has spun, I take culture to be those webs, and the analysis of it to be therefore not an experimental science in search of law but an interpretative one in search of meaning. (pp. 4-5)

Another working definition of culture conceptualizes culture as the "structures and practices that uphold a social organization by perpetuating and normalizing particular values, expectations, meanings, and patterns of thought, feeling, and action" Weedon, 1987 (as cited in Wood, 2000, p. 104).

Interpretation of culture varies depending upon context, but in regard to identity construction, culturally derived ways of being situated in the world are defining qualities of self-identity. One's culturally interpreted self-identity can be understood as an individuation of culture. Societal roles and rules prescribe and sanction specific ways of being in the world. According to a feminist perspective, people are situated differently

socially and materially within particular cultural settings, which allows for a particularly unique construction of a person's lived experience. Socially constructed aspects of culture such as gender, race, ethnicity, age, sexuality, ability, and status operate as interpretive standpoints that shape people's viewpoints and influence the construction of self-identity. The cultural self is situated in society based upon specified cultural prescriptions and beliefs. How one is situated in a cultural matrix can be conceived as *emergent standpoints,* which initiate in, foster, and mold interpretive aspects of self.

Extensions of The Cultural Self: Muted Groups, Standpoint, & Co-Cultural Communication Theory

The feminist cultural perspective of Muted Groups Theory centralizes the notion "that a language reflects a world view" (Kramarae, 1981, p. 3). The framework of the muted groups theory can be applied equally to any groups that are in asymmetrical power relationships such as women, gay men and lesbians, and racially, ethnically, or socially marginalized groups. States of inequality existing among groups within a particular culture "blocks the power of actualization of the other" (Ardener, 1989), which clearly plays a role in identity construction. Standpoint theory suggests that the context of a person's social location fuels their unique version (individuation) of reality (Hartsock, 1983, 1997a, 1997b; Wood, 1996c). Wood (1996c) utilizes the notion of people seeing through their "own sets of lenses" (p. 36) as a metaphor for cultural standpoint. In addition, standpoint theory centralizes how other cultural members interpret cultural others' interactions. According to Wood (2000), standpoint theory can be defined as how "the social, material, and symbolic circumstances of a social group shape how members

perceive, interpret, and act toward events, situations, others, and themselves" (p. 27). In addition, power asymmetry can be understood to be at the root of a particular group's *mutedness*. Language within cultural communication channels and structures is based on privileged members' constructions and contributions rather than made by those who are rendered invisible in the hierarchical mobility of privileged cultural members. Orbe (1998) refers to this notion as "co-cultural group communication" (p. 30). In addition, the use of the prefix, "co," implies an underlying sense of equality, togetherness, or mutuality in relating with cultural others rather than the use of descriptive language rooted in a rhetorical framework of power asymmetry. Terms such as minority, sub-cultural, subdominant, marginalized, disenfranchised, or even "muted group" (Kramarae, 1981; Orbe, 1998), tend to perpetuate ethnocentric bias in intercultural communication.

Hartsock refers to standpoint theory as "concrete multiplicity," which suggests, "knowledge production is a communal activity" (Welton, 1997, p. 19). She further explicates standpoint concepts to be understood as how race and sex as systems of domination influence class (p. 9). Additionally, Hartsock (1983) in her own words regards standpoint theory as praxis since "one can only know and appropriate the world (change and be changed by it) through practical activity" (p. 95). Another important consideration regarding feminist standpoint is that it "would raise, for the first time in human history, the possibility of a fully human community, a community structured by a variety of connections rather than separation and opposition" (Hartsock, 1983, p. 247). The combination of muted groups theory and standpoint theory into a unified co-cultural

communication theory supports a more integrated, holistic approach to the study of constitutive constructions of self and identity.

The Emergent Self: Dynamic Nexus of Intersubjective Interpretations of Self & Others

The Emergent Self is grounded in the perspective of the "agency of relational selves" (Wood, 2000, p. 125), and the agency of cultural selves. Wood (2000) suggests that shifting to an orientation of the self as relational tends to negate "a view of the self as singular and constant over time and space allowing us to enlarge our understanding of personal identity. Precisely because we internalize pluralistic perspectives into our consciousness, we are continually emerging, forming, in process" (p. 125). The model of the emergent self centralizes the multiple layers of self as a *dynamic emergent process* rather than a static or stable product. McLeod (1996) grounds his ideas about narrative therapeutic constructions of self by stating "Polkinghorne argues that . . . [social and physical indices of the] . . . self-concept ignore the existential notion that the 'self' is not experienced as a static 'entity' but as a process of becoming" (p. 44). The emergent self is always in a state of *becoming* as we shed and/or edify our old interpretations of self by replacing them with new and/or reconstructed versions. This emergent process is constructed within the on-going communication that occurs between the intersectionality of our experiential self within cultural and relational contexts.

Self-Narration & Communication as a Means of Emergent Identity Construction

Gergen and Gergen (1993) argue that narrative accounts of self are "products of social interchange—possessions of the socius" (p. 18). The structure of narrative self-accounts can be understood as a person's socially constructed perceptions of self because

self-narrative is always embedded in a social milieu (Richey, 2001). A person's lived experience is the basis upon which narratives originate. Self-narrative (formed within intersubjective interpretation of a person's lived experience) functions as "a mirror to nature" (the lived world), which motivates storytelling (Gergen & Gergen, 1993, p. 20). A following explanation of the processes involved in the emergence of self clearly situates self-construction in sociocultural communication:

> Self-narration performs the functions of self-understanding and social conduct, making the process of self-construction a relational process rather than a solely self-realized process. The self, like the communication in which it is constituted, is social in origin. (Richey, 2001).

Narrative therapeutic strategies, for example, challenge the individual precisely in the site where reality construction and reconstruction originate. McLeod (1997) explicates this concept in a social constructionist framework:

> Classical psychoanalysis employs an image of the person as combined mechanism (the 'hydraulic' model of libinal energy) and organism (the 'id'). These images convert into images of therapy: a mechanism is 'fixed', an organism is 'healed', a computer is 're-programmed', a person 'grows'. Those who have developed and espoused social constructionist approaches to therapy regard these images as inadequate and limiting. . . . They are limiting because they are images that implicitly deny the capacity of the person to be aware, to challenge existing oppressive social structures, and to be creative in developing new ways of living together. Social constructionist therapies are based in an image of the person as a

> *social being*. . . . From a social constructionist perspective, any way of making sense of the self is socially constructed, and can be understood as deriving from a particular set of social, cultural and historical conditions. (p. 90)

Application of the Emergent Self in Healthcare Recovery Strategies

Other forms of self-narration occur in therapeutic encounters, which function to reconstruct a person's self-concept (Gergen, 1994a, 2001; Gergen & Gergen, 1993; Lorber, 1997; McLeod, 1997; Polkinghorne, 1988; Richey, 2001; Sabat, Fath, Moghaddam, & Harré, 1999; Shotter, 1991). Shotter suggests that people's self-identities are "re-authored" from the perspective of "what to be" in life rather than "what to do" and "what they have been in the past, to enable them to face what they might be in the future" (Shotter, 1991, p. 105). In this regard, therapeutic strategies for health behavior change which centralize the role of communication in identity reconstruction, tend to be more effective than forms of treatment that target already formed attitudes, health beliefs, health behaviors, or health outcomes as the locus of health behavioral change. Positive health behavior change is an emergent, constructed part of the interpretive, sociocultural communicative process involved in the reconstruction of self. A social constructionist perspective of the emergent self emphatically rejects a disease model explanation for addiction and health behavior change. Instead, people's potential for positive change in health behavior is constitutively embedded and reconstructed within the systems of the emergent self—which is an interpretive, intersubjective process of constant self-reconstruction.

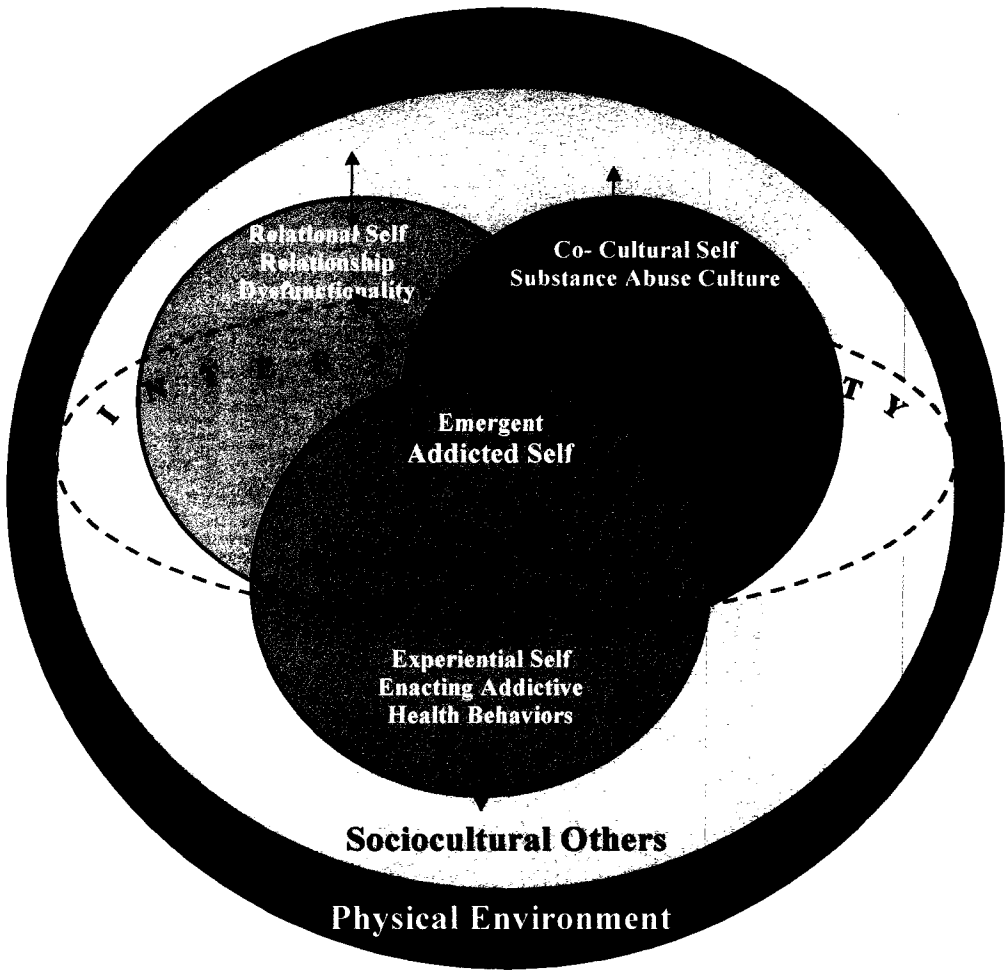
For example, anti-tobacco media campaigns in Alaska over the past decade have focused on fear appeal messages regarding smoking health outcomes. The aspect of fear appeal in anti-tobacco messages shows in graphic detail negative health outcomes of smoking illustrated through photos of blackened lungs or emphysema, and cancer victims breathing through stomas. Although concurrently, in the state of Alaska from 1990 to 1995, the incidence of cigarette smoking in adolescents spiraled upward; in particular, cigarette smoking increased by 26 percent among American Indian/Alaska Native youth. And, recently the American Lung Association indicated Alaska Native adolescents have the highest rate of smoking in the nation—34.1 percent (State of Alaska, 1999). A reasonable critique of health behavior messages, framed as fear appeals, could indicate without addressing agency (self-construction) as the way in which behavior changes, they fail. Witte (1992), who includes personal differences [sic, emergent self] as an integral aspect in her discussion of an extended parallel process model in regard to fear appeals, compares people's responses to fear through appraisals of threat and efficacy (p. 338). In this regard, people "evaluate the components of messages in relation to their prior experiences, culture, and personality characteristics . . . the same fear appeal may produce different perceptions in different people, thereby influencing subsequent outcomes" (pp. 338-339). The conceptual framework of the emergent self extends Witte's cognitive expectancy value approach to fear appeals, by locating the source of behavior change as a socially constructed process within a person's intersubjective lived experience. In this sense, for a fear appeal message to be personally effective, it should enter into the

sociocultural communication system within the individual's relational and cultural interactions—the construction sites of the emergent self.

The perspective of the social construction of the emergent self can be effectively applied to alcohol abuse and other substance abuse as well. The following model (Figure 4.2) depicts how a socially constructed process perpetuates addictive behavior in the emergent self. The triadic interplay of the self-systems of communication within the model reinforces interpretations of self as the *addicted self.* People embroiled in alcohol abuse or substance abuse tend to create and to maintain the emergent self as the addicted self, through interaction within dysfunctional family and personal relationships, and maybe even in "disease model" therapies (Beattie, 1989; Beck, 2001; Gergen, 2001; Lorber, 1997; Irvine, 1999; McLeod, 1997; Schaef, 1986, 1987). In addition, they continue to move within alcohol abuse or substance abuse social circles reinforcing and reenacting addictive behaviors. In order to shift one's self-interpretation of addiction, a change in self-knowledge must somehow be enacted through the self-systems represented in the model.

Co-Researchers' Stories of the Addicted Self

As I began to think about how the modeling of the social construction of self-identity might work in the lived experience of my co-researchers, I contrasted aspects of change in health behavior as told in their stories with the three models of health behavior change: (a) Theories of Reasoned Action and Planned Behavior (TRA/TPB) (Figure 2.1), (b) Transtheoretical Model and Stages of Change (TTM) (Figure 2.2), and (c) Social Cognitive Theory SCT) (Figure 2.3). I became discouraged when using the *a priori*



The Addicted Self is the same as the Emergent Self in the model. Any (health) behavior can be overlaid onto the Social Construction of the Emergent Self Model since the process of self construction is contextually mediated by communication within a sociocultural matrix. A multi-layering of subcultural contexts and diversity of relationships are implied in the model.

Figure 4.2. The Emergent Addicted Self – Re-enactment and reinforcement of addictive substance abuse behaviors in the self-systems within network of sociocultural intersubjectivity.

models of health behavior change because the constructs embedded in these models did not fully address the type of changes I was hearing my co-researchers talk about in their stories of recovery. For instance, the constructs in the TRA/TPB such as a person's attitude toward the behavior and perceived behavioral control reside within the person. However, I was hearing my co-researchers speak of problems in relationships (the *emergent between* from the emergent self model) and how their family relationships affected them. Even though, the TTM has a very practical delineation of stages of change we all tend to move through when making health transitions, a notion of relationship to others tempering our changes for bad or for good is only mentioned as "helping relationships" in the "processes of change" (Prochaska, Redding, & Evers, 1997). As the researcher I asked myself, what about problematical relationships and their connection to change in health behavior? The SCT utilized the construct of the environment as part of its triadic model, which includes a person's social environment, but even this is too broad a concept when attempting to define the function of personal relationships in a person's ability to make effective health behavior change.

The TRA/TPB and TTM as health behavior models failed to answer the question about the nature and influence of personal relationships regarding people who chose to make health behavior changes. If I wanted to study the constructs from these health behavior models in the lived experience of my co-researchers, I would have to ask detailed and probing questions related to these constructs. In other words, I would have to have had this model in mind as I approached my interviews. And rather than my co-researchers telling authentic stories of recovery, they would be answering specific guided

questions related to a model's constructs. The aim of narrative research method does not include the use of *a priori* models to mold interview questions, rather narrative interviewing solicits authentic lived experience from co-researchers through the telling of their own story.

The dilemma of not being able to fully understand a person's changes in health behavior through these models led me to wonder how the social construction of self might by modeled. To my knowledge, no prior model depicting the social construction of identity existed before I constructed this model as part of my post-graduate work. My theoretical view in research is grounded in Constructionism (Crotty, 1998) and concepts of social construction, the co-construction of self (Gergen, 1991, 1994a/1999, 2001; Gergen & Gergen, 1993, Gergen & Warhus, 2001; Harré, 1989; Harré & Gillett, 1994; McLeod, 1997) and social construction of health and illness (Beck, 2001; Lorber, 1997). Therefore, a logical progression of theory and research inquiry led me to attempt to model the social construction of identity in regard to health behavior change—specifically related to the transition from an addicted self identity to a recovery identity. The modeling of the social construction of the emergent self was the end product of my research inquiry process.

I found I could easily and equally apply my model of the Emergent Self to the process of the emergent addicted self as well as to the emergent recovered self. In order to understand how the model depicts the process of identity construction in the addicted person's lived experience, the co-researchers' stories need to be applied to the model. The stories of four co-researchers who represent a range of alcohol dependence and/or

abuse were selected to discuss within the framework of the addicted self model: (a) Jesse, (b) Denise, (c) Ester, and (d) Amanda. Jesse's former behavior (binge drinking) with alcohol represents one end of the abuse continuum. Binge drinking refers to the consumption of five or more alcoholic drinks in a short period of time. On the opposite end of the alcohol abuse continuum is the former

drinking behavior of Amanda described her drinking behavior as "really bad . . . I was living on the street."

The other three co-researcher's alcohol drinking behavior fell in between these two extremes. They all suffered from alcohol dependence/abuse in varying degrees. Each woman enacted the behaviors of the addicted self during her drinking career. And sometimes the emergent quality of the addicted self was reinforced over and over again through alcoholic sociocultural interaction. For example, Jesse described being socialized in an "athletic" environment where weekend alcohol binges were normalized. Denise spoke of increasing her drinking behavior after college from "weekend binge drinking" to "partying everyday" with others. Ester described wild "hippie" style teenage drinking and drug behavior that settled into chronic drinking patterns in an "alcoholic marriage." Amanda spoke of "getting drunk" in a bar and leaving with a strange man who tried to rape her outside in a field.

The common thread running through all the women's narrative comments relates to "drinking" with other people in a social environment based upon alcohol drinking behavior. In regard to the model of the emergent self, the co-researchers were enacting an emergent addictive self (Figure 4.2) through intersubjective interpretations of their

experiences of being immersed in a drinking culture—an aspect of the cultural self component within the emergent self model. All four women spent many years inside the cultural environments that perpetuated their dependent and abusive drinking behavior. Each woman spoke of being involved in personal relationships with partners who were alcohol abusers as well. The co-dependent (co-alcoholic) nature of an alcoholic relationship can be seen in the narrative comments from these women's stories. The second system in the construction of self, the relational self, is clearly enacted in the women's stories. Amanda described the tension and temptation of teetering on the edge of returning to her former drinking behavior because she was living with an "alcoholic boyfriend" whose "self-esteem is really low . . . my big struggle now is allowing him to drink in our home." She has been sober (abstinence) for over 11 years, but because she stay within an alcoholic partnership, she describes "wanting to go to the bar . . . sit and drink with him." Amanda describes her struggle with this aspect of her relational life as "one of these times he's going to get me where I can't get back up." She is afraid that if she stays with this man who abuses alcohol that her resolve to stay sober (abstinence) will eventually break.

Ester spoke of being entrenched in a long-term marriage with an alcoholic husband. They both were active alcohol abusers until she bottomed out. Her husband continued to drink during her first 5 years of sobriety (abstinence). She and her husband broke up after 25 years of marriage. He had gotten involved with another woman who drank. Ester mentioned "if I was going to drink it would have been at that time . . . my first thought was to pick up the loaded shotgun and blow him away . . . the second

thought was . . . go call your sponsor." Ester's believes her A.A. program commitment saved her during the traumatic end of her marriage.

Jesse told stories about how her relationship with her alcoholic father deeply affected her emotionally. She tried to emulate his drinking behavior when she was a teenager and a young adult because "it was something we could share . . ." She tried to fit in with his alcohol behavior to share in a part of his world. Denise spoke of always choosing "partners who were partaking" in alcohol. When she began making changes in her drinking behavior the alcoholic relationships and "partyers" had to go. She described how a relationship formed the impetus for her to change her own behavior with alcohol, "I was trying to balance going out and having a good time . . . coming home . . . having people drinking around me . . . I became an enabler . . . subsequently my next two relationships were with people who weren't drinkers." Denise recognized aspects of herself in her choices of relational partners. Her emergent addicted self identity was shifting toward a new construction of self as a recovered self. The stories of alcohol dependence and alcohol abuse in these four narrative accounts speak to the interconnectedness of cultural and relational interactions in the construction of the self identity.

Health behavior interventions designed to help a person shift one or more of the self-systems tend to be more effective (Brown & Lewis, 1999; Brown, 1995; Gergen, 1994a, 2001; Lewis, Blevins, & Dana, 2001; Marlatt, 1998; McLeod, 1997; Miller, 1986, 1989; Thompson, 1992; Van Wormer, 1995) than interventions focused on negative

health behaviors or potential health outcomes. In contrast, a *recovered self* or the reconstructed self can be effectively represented within the self-systems in the model of the social construction of the emergent self (Figure 4.3). The emergent self is shown here as the person actively engages in the process of identity reconstruction (Brown, 1995; Gergen, 1994a, 2001; Lewis, Blevins, & Dana, 2001; Marlatt, 1998; McLeod, 1997; Miller, 1986, 1989; Sabat, Fath, Moghaddam, & Harré, 1999; Thompson, 1992; Van Wormer, 1995) through positive and supportive interactions. The formerly addicted person systematically and incrementally shifts intersubjective interpretations of self toward positive health promoting interactions in all self-systems including self-narrations (Gergen & Gergen, 1993).

Co-Researchers' Stories of the Recovered Self

Excerpts from the co-researcher stories are utilized to describe the process of the emergent recovered self (Figure 4.3). Five co-researchers' narrative comments are applied to the constructs of the relational self and the cultural self within the model in order to describe their process of constructing a recovered self: (a) Maggie, (b) Beth, (c) Frances, (d) Morgan, and (e) Bobbi. Maggie speaks to the pervasive influence of positive personal relationships in the construction of her sense of the recovered self: "one very important issue of my life was fulfilled . . . I'd like to give credit where credit is due. For the past 10 years I have lived with a significant other, who also has 11 years of recovery . . . what a balancing touch that has added to my serenity." Maggie also serves as a source of "inspiration" for her mother who has been sober (abstinent) for the past 13 years.

Figure 4.3. The Emergent Recovered Self – A healthy shift in more than one of the self-systems within the construction of the emergent self leads to eventual healthy transitions in all self-systems within the network of sociocultural intersubjectivity.

A positive relational influence was perceived by Beth when her friend gave her a book on recovery to read: "A friend . . . had given me a book to read . . . that was what I need to learn . . . how come I did not know about . . . boundaries . . . and control?" Frances speaks of positive aspects of attending A.A. meetings: ". . . the thing you learn when you go to a lot of meetings is not only do you develop a friendship that keeps you sober, but your start to recognize a part of your story that is like other people's [stories]." Morgan reinforces the notion of being supported in her construction of a healthy recovered self through her relationship with her daughter: ". . . the other person who is significant in all of this is my daughter . . . we share . . . a publication . . . called the Grapevine . . . I read them and mail them to her . . .the idea is to . . . reinforce the positive messages of the program on a daily basis . . . I'm the only family member she has . . . [who has] been to a program [for alcohol problems]." Finally, Bobbi speaks of her evolving sense of the emergent recovered self by being swayed into going to Al-Anon with her partner: "my current partner switched my focus [from A.A.] to Al-Anon and my co-dependent characteristics." Bobbi was able to construct a new dimension of the emergent, recovered self through the influence of her relational partner.

The cultural self in regard to the recovered self is demonstrated through the narrative data as well, such as Maggie's comments about being immersed in a prevention and recovery cultural environment every day on her job: " . . . my heart is in working with kids . . . we reach out to high schoolers and younger kids . . . I share my story . . . I try to mentor." In addition, Beth speaks about being committed to her cultural identity by helping people in her home village: "I am part of this movement, the Native movement . .

. something happened where I just want to learn." She expressed feeling as if she had no sense of a cultural identity when she was young and abusing alcohol and drugs: ". . . I was living in two worlds . . . I did not live my reality well . . . none of us did."

As a member of a Christian church, Frances describes receiving support in that environment: " . . . I turned to the church instead of A.A. . . ." She mentions that she eventually found support in A.A. after failing to connect with others in her treatment group: " . . . for whatever reason I didn't make any close friends in the group . . . I didn't see them at A.A. meetings . . . I didn't connect . . ." Frances identified strongly with the people in the culture of A.A. and Narcotics Anonymous (N.A.). Morgan reiterates the notion of being involved with like others in a cultural environment: "I sought out people . . . who don't do any drugs or alcohol . . . if a person drinks and uses then I don't want to be around them . . . we tend not to have very much in common after a certain point." Lastly, a notion of the cultural self is exemplified by Bobbi's comments regarding her exploration of her Native American ancestry and spiritual viewpoint: "I though I had was into the wrong church . . . if I could find God, I'd be okay . . . God is right in here (pointing to self0, but that came from my Native American spiritual philosophy . . . that is still my root." Bobbi recognized the value of her connection with her Native American cultural self in the construction of herself as a recovered self. The co-researchers' narratives supported the cultural self construct within the framework of the emergent self model as being an integral aspect of identity construction toward an emergent, recovered self.

Summary & Conclusion of Constructionism, Communication, & Health Behavior Change

A social constructionist perspective in regard to a person's ability to change health behavior centralizes socially and culturally situated interactions with others as well as one's self-narrations as constitutive to a reconstructive process of healthy change. The focus of the model suggested, the social construction of the *emergent self*, is understood as *a process of becoming*. In this respect, a person involved in recovery from negative health behavior, such as recovery from alcohol abuse or substance abuse, continuously reconstructs the identity through interpretation as the *recovered self*. There has been an on-going semantic tension in various addiction treatment and recovery programs in regard to an operating framework of a person as *recovering* versus *recovered*. For instance, the abstinence perspective of A.A. regards people who abuse alcohol as never "fully cured" from the "disease" of alcoholism [sic]—they are always in a state of recovering (A.A. 1976). In contrast, other alcohol abuse recovery experts recognize the ability of the person to reconstruct the self in regard to alcohol use (Chiauzzi, 1991; Denzin, 1987a, 1987; Marlatt, 1998; Miller, 1982, 1985, 1986, 1996; Miller & Heather, 1998; Miller, Andrews, Wilbourne, & Bennett, 1998; Sobell & Sobell, 1999; Sobell, Ellingstad, & Sobell, 2000; Vaillant, 1983, Van Wormer, 1995). The difference relates to framing recovery as a process rather than as only an attained condition. A conceptualization of the person as constantly involved in a reconstructive process through interpretation of lived experience and through sociocultural interaction replaces this tension with the notion that both perspectives can be incorporated through the self-systems of the emergent self. In this view, a person can be actively recovering as they emerge as the recovered self.

The model of the emergent self describes how social construction within human communication drives a person's strategies in identity construction as the addict or the recovered person. The traditional framework of health behavior change understood through the disease model may in part describe how the addiction process works in a human body, but fails to capture the true essence and complexity of how an addicted person shifts his or her attention toward recovery. Therefore, additional explanations have been created to describe the recovery process. In this sense, health belief and health behavior theories and substance abuse treatment/recovery theories have included notions of self-identity, self-efficacy, social interaction, and social support to more fully describe a person's recovery process (Ajzen, 1991; Ajzen & Fishbein, 1980, 2000; Bandura, 1986, 1997, 2001; Beck, 2001; Broman, 1993; Chatham-Carpenter & DeFrancisco, 1997; Cohen, Gottlieb, & Underwood, 2000; Cornelius & Day, 1997; DiClemente, 1999; Finkelstein, 1996; Gergen, 2001; Gergen & Gergen, 1993; Josselson, 1995, 1997; Lakey & Cohen, 2000; Lorber, 1997; Marlatt, 1998; McLeod, 1997; McNamee & Gergen, 1999; Prochaska, Redding, & Evers, 1997; Segrin, 1992, 2000; Shotter, 1991; Strecher & Rosenstock, 1997; Thompson, 1997; Van Wormer, 1995; Wood, 2000, 2001). Health belief and health behavior models tend to be constructed abstractions applied to people's health attitudes and behaviors and are essentially subsumed within the processes of the social construction of the emergent self. Constitutive change in self-identity occurs as an on-going process of *becoming* through an interpretive process through the systems of self and social interaction as described in the emergent self model: (a) the *experiential self*, (b) the *relational self*, and (c) the *cultural self*. This interactive, intersubjective dynamic

process of communication between self and others is the primary process underlying all constructions of human reality and co-constructions of self-identity.

The social construction of the emergent self is a theoretical communication model that centralizes the process of human communication. A communication perspective applied to health behavior change suggests that people are sociocultural actors who interpret their reality and constructions of self through an on-going matrix of social interaction. Communication models created from a positivistic perspective tend to compartmentalize constructs outside the framework of social interaction and apply them in an abstract, linear-sequential fashion, which is antithetical to how human beings actually construct their realties. The site of reality construction and identity creation takes place intersubjectively in a complex interpretive process. In this regard, strategies aimed toward health behavior change should centralize communication and the notion that self-identity is a socially constructed emergent process constituted in social communication.

Narrative Emergent Themes: Constructing the Recovered Self

The purpose of the present study was to explore the lived experience for shared meaning regarding women living in Alaska who have been successful in long-term recovery from alcohol dependence and/or abuse. Those shared meanings of lived experience are representative of the interpretative derivations of descriptive consistencies in the capta that imply thematic structures within the co-researchers' autobiographical stories. These stories of self provide the criteria with which narrative interpretive strategies render a woman's self-descriptions as indicative of a construction of self-

identity. In so doing, a notion of the "emergent self" (Richey, 2003) as discussed fully in chapter three of this study suggests that a person's identity is constitutively organized through the overlapping tensions of sociocultural interactions acting on self. Therefore, the emergent self can be understood as the ever-evolving culmination of a triadic intersubjectivity involving the experiential self, the relational self, and the co-cultural self; the emergent self, therefore, is in a state of constant construction depending on a person's interpretations of intersubjective self-definitions.

These shared meanings synthesized from co-researchers' narratives provide a cogent understanding of the process of identity construction. As in the case of recovery from alcohol dependence and/or abuse, a woman's shift toward a healthy lifestyle free from alcohol problems can be understood through her process of constructing the self as the *recovered* self. The emergent thematic structures synthesized in this study represent an aspect of shared meaning and are indicative of suggested *core* mechanisms of successful self-change in women who have maintained long-term recovery from alcohol dependence and/or abuse. I interpret two primary emergent themes from the co-researchers' narratives of long-term recovery: (a) Survivorship, and (b) the Transcendent Self. A dialectical tension within the themes was evident in the co-researcher's narratives, which were foundational to their addictive behaviors prior to recovery. Also, there were two underlying thematic descriptors in the stories, which relate to the enactment of addictive health behavior involving alcohol and substance abuse: (a) early drinking age, and (b) childhood and/or spousal abuse. Lastly, thematic data present in five out of the nine narrative autobiographies was a Native American cultural relationship

to alcohol, which is offered for discussion as a tentative narrowed topic for future research on alcohol dependence and/or abuse.

First Emergent Recovery Theme—Survivorship

Common knowledge stipulates that alcohol dependence and/or abuse is very destructive to a person's physical, mental, and emotional well being. Cessation of alcoholic drinking behavior literally causes a person to go through stages of healing on these three levels over time. A notion of survivorship relates specifically to a holistic sense of recovery, in that people, who are successful in their recovery attempts, do actually survive their former negative, self-destructive health behavior as well as survive other situations present in childhood, adolescence, or young adulthood such as physical, emotional, or sexual abuse. Statistics regarding the victimization of women addicts, according to a 1994 study by Brice, Grady, Dunstan et al., indicate that "80 percent of the women entering treatment for addiction had a history of sexual abuse . . . 32 percent had been abused before the age of 11" (as cited in Evans & Sullivan 1995, pp. 6-7). However, survivorship can be understood in other ways too such as in a person's *will to survive*, through a person's *resistance* or *stubbornness,* or through the exercise of *choice.* O'Hair et al. (in press) in their study on cancer survivorship, have identified several characteristics integral to successful survivorship such as "empowerment and agency" (p. 3). Although the O'Hair et al. (in press) study centralized a cancer victim's survivorship, the ideas regarding the criteria necessary for successful survival are applicable to an understanding of alcohol dependence and/or abuse survivorship.

References to the concept of survivorship emerge from the narrative data of all of the co-researcher's narratives through the concepts of resistance, willfulness, stubbornness, independence, agency, and choice. For example, Maggie spoke several times about being very "stubborn" such as when she had to repeat an anger management course:

> I was so stubborn I ended up taking anger management three different times . . . breaking through denial is like breaking through cement . . . you're raised a certain way—you're stubborn. I am a very stubborn person . . . I'll show you . . .

Maggie also indicates her sense of self-perceived stubbornness by stating, "cuz, I'd rather do it myself." Her self-described interpersonal characteristic of refusing help or stubbornly insisting on things being done in her own way, even if it meant that she had to repeat a crucial course on anger management three times, when transformed toward her recovery speaks to her strong will and capacity to commit to change. It seems that personally constructed ways of being resistant or stubborn often become the very characteristics that enable a person to ultimately survive abusive behavioral patterns—whether perpetrated by others or self-inflicted. Ester articulated support for this point clearly by stating,

> . . . I am a willful person in fact that is the only thing that has allowed me to survive all of this—my willfulness. I am a very difficult person . . . which is why I am surviving right now . . .

Ester reinforced this viewpoint of survivorship later in her story telling when she indicated that:

> . . . I made a commitment. The same tenacity of will that kept me going through the addiction is the same thing that kept me going through sobriety . . . I have a tenacity that is unbelievable, really . . . it's part of my personality.

At the very end of her narrative interview, Ester articulated the survivorship theme once again by stating:

> . . . I have a personality that is set up for survival. I am an incurable optimist . . . and tenacious in health. You'd have to cut my hand off before I'd let go. That's why I bottomed out because I wouldn't let go . . . either you hold onto . . . addiction or hold onto . . . sobriety . . .what was killing me is now serving me . . . the tenacity . . .

Ester's "tenacity," which she believed was a fundamental personal quality keeping her stuck in negative behavior patterns, also acted as a source of empowerment for her in constructing and maintaining her sobriety.

The emergent theme of survivorship is exemplified through Beth's discussion regarding her intolerance for not being able to take any more emotional abuse from her mother. Beth spoke of her will to survive, by stating:

> . . . I was one daughter that would not put up with the . . . B.S. . . . I could not take it anymore . . . I could not stand for her to put my father down anymore . . . I stood up to her . . . started living MY life.

Later on in her narrative, Beth talked about her own stubbornness saying "I have never been one to seek help anywhere . . . I've been very independent." Her self-perception as

independent seems to have strengthened her capacity for her eventual survivorship of alcohol dependence/abuse.

Bandura (2001) suggests that people make changes because they "have adopted an intention . . . an action plan. . . . Agency . . . involves . . .[an] ability to give shape to appropriate courses of action . . . to motivate and regulate their execution" (p. 8). In Jesse's narrative interview stubbornness, independence, agency, and choice are exemplified in her comment, "I had to do it on my own." Amanda reinforces this concept of agency when she asserted that "I had a strong will to refrain from drinking." Additionally, her will to survive can be understood from the notion that she did not want to be victimized by her former ways. She forcefully claimed she doesn't " . . . ever want to walk down that road again." Morgan's comments from her narrative interview added even more support for a notion of agency and empowerment in regard to survivorship in that she exercised "gritted determination" to continue following her course of action when deciding to become sober. Lastly, Frances spoke of agency, as well, through her comment that she wanted "to be in charge of at least . . . myself." Agency, will, tenacity, stubbornness in these narratives of recovery ground not just a commonality of experience but also an attitude of motivations; a determination to: "take back my life;" to survive.

The personal choice to view the world from a survival perspective negates a victim orientation. In the process of interpreting the thematic structures in the narratives, I noted the absence of a sense of *victim hood* in the shared meanings. Goldstein (1997) refers to this dichotomy of survival as a question of "victors or victims" and suggests that human beings who survive trauma do so because of the function of socially constructed

"strengths and resiliency" (p. 26) within their own interpretations of self and reality. This viewpoint coincides with the construction of the emergent self explicated in this chapter in which identity construction is intrinsically connected to intersubjective interpretations within a sociocultural milieu. This survival perspective, constitute framework of a person's lived experience of trauma and life challenge. Although, several of the co-researchers refer to their "tenacity" or their "willfulness" as *personality traits*, their adaptation to change is more clearly understood as a "construction" (Gergen, 1991, 1994a/1999, 2001; Gergen & Gergen, 1993, Gergen & Warhus, 2001; Harré, 1989; Harré & Gillett, 1994; Lorber, 1997; McLeod, 1997) constituting the self emergent from addiction as being *recovered.* Another way of understanding this point is to centralize the construction site of self-identity as occurring "between" self and others. Overall, the lived movement co-researchers named as concepts of willfulness, tenacity, stubbornness, and empowerment that feed into the shared experience of survivorship are descriptive of the recovered identity and quality of agency. What was experienced in the addicted self as resistance to influence that supported alcohol dependent behaviors is transformed in the experience of recovery into the sustained ability to overcome abusive alcohol related behavior. The theme of survivorship then derives from the shared experience of the women coming to recognize their ability to shape their own lives and exercising that control to reject alcohol dependence and/or abuse.

Second Emergent Theme—The Transcendent Self

A recent trend in therapeutic counseling has been the inclusion of a spiritual perspective. There is a paradigm in psychology called a transpersonal approach that

explores the "transegoic" (Valle & Mohs, 1998, p. 99) and ineffable experiences in people's lived meaning. Mohs, Valle, and Butko (1997) suggest that the utilization of spirituality or a transpersonal viewpoint in therapeutic strategies, especially in regard to alcohol dependence and/or abuse, allows one to "move beyond and through the personality [sic] . . . to become aware of one's essence" (p. 1). Additionally, the use of a spiritual perspective in working with people in recovery from addiction not only honors very deeply felt personal awareness but also opens up a dialogue regarding epiphanic experiences of personal transformation (Gregson & Efran, 2002; Marlatt & Kristeller, 1999; Miller & Thorensen, 1999; Miller and C'de Baca, 2001; Mohs & Valle, & Butko, 1997; Moxley & Washington, 2001; Richards, Rector, & Tjelveit, 1999; Valle & Mohs, 1998).

The second core emergent theme distilled from the narrative interview capta is a notion of the *Transcendent Self* in regard to maintenance of long-term recovery. According to Miller and C'de Baca (2001), people often are at a loss for words to describe "mystical type" (p. 75) experiences and hesitate to share them as well. However, when a person initiates a dialogue in daily life to articulate the lived experience of a profound connection with ineffableness, his or her range of options for coping well is increased. If we understand the essential nature of reality and identity construction as an intersubjective process, then, a person's sharing of spiritual understandings acts to stimulate new co-constructions of self in regard to lived and shared meaning. Personal growth and awareness is an obvious outcome of new identity construction. The synergistic act of sharing inner thoughts of connection regarding ineffability, no matter

how nebulous or weird these thoughts may seem, helps to open up new insights and a foster a sense of possibilities or choice for a person. The incorporation of a spiritual perspective in a person's reality construction tends to strengthen one's sense of self-efficacy because of a sense of being supported socially (e.g., church, spiritual organizations such as A.A.) and "this support does not rest solely in people or animate objects but may emanate from nonmaterial sources" (Sullivan, 1997, p. 187).

In regard to the narratives of the women in recovery from alcohol dependence and/or abuse in this study, a spiritual perspective on life and/or the experience of transcendence were an integral part of their newly constructed sense of self as a recovered person—their "emergent *recovered* self" (Richey, 2003). Each co-researcher recounted stories of epiphanies, miracles, or an experience of a "higher power" (A.A., 1976). The emergent theme of the *Transcendent Self* represents shared meaning among the co-researchers in regard to self-change and the maintenance of long-term recovery. In contrast, the absence of connection with the Divine was highlighted in many of the narratives as a prelude to a transcendent breakthrough on the road to recognizing oneself as a recovered self.

First, the absence of a spiritual base or outlook is illustrated in the various narratives such as Bobbi's story about being in A.A. and not having a connection with a higher power:

> . . . the rest of it was hard . . . it was like mumbo-jumbo to me. I didn't like the religious spirituality part of it. I was a really stubborn and strong willed person and I didn't like . . . this book . . . I can cross out god and I think I did. I still have

> the Big Book where I crossed out the word god until I got my first sense of a higher power . . . I didn't have a concept of a higher power then.

Over time Bobbi was able to construct a deep understanding of a higher power. Beth spoke of "being dead on the inside" and " not having a relationship with a higher power the way [she] knows it now." Ester described her non-sober experience of the absence of spirituality in her lived experience by stating: ". . . I couldn't feel god . . . I couldn't feel Jesus . . . I couldn't feel anything."

Secondly, the shared meaning from the narratives supported the emergent theme of the *Transcendent Self* in regard to co-researchers' ability to recognize a higher power in their lives and construct a working sense of spirituality. For example, during Denise's recovery she became a "Buddhist . . . in the midst of all this . . . quieting a lot of negative chatter . . . in my head." In recovery, Ester had a sponsor in A.A. who became her "spiritual guru . .. she got me on a very deep spiritual path." As Ester grew spiritually, she adopted the Bahai faith, but she mentioned that it "took . . . [her]. . . a long time to become comfortable with God." Ester described a transcendent experience when "two women like a couple of angels" from A.A. showed up on her doorstep when she called for help. Another example of the significance of spirituality and a belief in a higher power for a woman in recovery can be understood from Morgan's story when she described her experience of almost choking to death while abusing alcohol and cocaine:

> . . . I made that magical promise to God that if I lived through this I would stop all substance abuse . . . and I lived . . . a lot of people would just go on their merry

way and ignore that, but I take my relationship with my higher power very seriously . . .I made a promise to God and I don't break my promises to God . . .

Morgan who had at the time 12 years of recovery under her belt had an epiphany one day while watching a television soap opera. She described the experience of the moment as "hearing that little voice inside my head saying, 'you should go to an A.A. meeting!" A final example from Morgan's narrative relates to the spiritual quality of the A.A. program in her opinion:

> . . . the program is a spiritual program it is not a religious program. Whatever your religion or lack of it has nothing to do with this. The program suggests your relationship with your own higher power as you understand your higher power . . . one of my most powerful experiences . . . was that . . . I was secretly binge eating . . .I thought that maybe, I can deal with all of that too . . . and I asked . . . I did what one of the steps asked rather than related to alcohol . . . I just didn't want to binge eat anymore . . . could you take this away . . . and that was it . . . I never binge ate again . . .

Morgan was able to use her understanding of the spiritual process of the twelve-steps in A.A. to transcend her eating problems as well as to work on her addictive behaviors and to maintain her recovery from alcohol dependence/abuse.

The supportive power of spiritual fellowship was demonstrated in Jesse's narrative when she joined in on a spiritual retreat, "I was thrilled to no end . . . I met some wonderful people . . . I learned a lot . . . that was quite an experience . . . going to that church . . . they were so loving, . . . forgiving, and caring . . . it was actually a great

environment." Over the years Jesse has tapped more into her Native American roots by learning about various Native healing perspectives such as "burning sage . . . clearing out the negativity . . . opens up the positive energies." The Transcendent Self theme was supported in Beth's narrative when she told a story about opening up to God:

> . . . I knew I had to have a better life. . . Inside of me I knew . . . I got on my knees and submitted myself to God or a higher power . . . I gave myself to Him . . . okay, here I am . . . I was really drinking it all in spiritually . . .

Beth said that her "serenity started to grow and grow." Amanda's narrative also demonstrated a strong recognition of the power of spirituality, "I was . . . eight months pregnant and I came to know the Lord . . . I took Him into my heart and that's how I have been sober all these years . . . I find my strength in the Lord." Beth goes to church regularly and described her process of dealing with the temptation of drinking again "God always finds a way to bring me back up . . . it is just a thought and God takes it away." Beth's apparent deep belief in God and Jesus represent her construction of spiritual belief in the sense that she believes very strongly that God takes away her desire to drink.

Spirituality is very important to Maggie as well. She described her connection to her higher power:

> spirituality did and does play a big role in my recovery . . . it is my belief that it is the one stumbling block that . . . people struggle with in early recovery. . . A.A. gave me the support to be able to 'learn how to live sober' . . .

Maggie is totally committed to her work and service in A.A. and understands the organization as a "spiritual" process in that A.A. "has empowered [her] to be where [she] is today."

Frances' narrative demonstrated her sense of spirituality in that she described herself as "belonging to a Methodist church." She too is a committed A.A. member who appreciates the social and spiritual support she gets from going to meetings:

> when you go to a lot of meetings . . . you not only develop a friendship that keeps you sober, but you start to recognize a part of your story that is like other people . . . it helps you identify . . . things about yourself . . . that you never would have realized . . . you become teachable . . .

Finally, the emergent theme of the transcendent self is exemplified in Bobbi's narrative story when she talked about her experience of being a member of A.A., "when I first got interested in recovery . . . it opened up my spiritual experience." Bobbi's own sense of transcendence is that "God is right here (she thumped her chest several times) . . . but that came from my Native American spiritual philosophy more than anything else." Bobbi expresses her spirituality through her art work, "it's a wholeness philosophy . . . which I express through my art . . . I am aware that I am in a self-reflective process and I see you and me . . . the commonalities with other human beings." Bobbi's last comment in regard to her spirituality was that her "worldview had to shift" when she began to recover. This "shift" was a new construction of self as the *transcendent self* within the framework of a *recovered self* as well.

The process of transcendent self-change is a crucial component within a woman's capacity to construct a *recovered* identity, which is well grounded in a personally relevant, practical, and evolving sense of spirituality. According to Richards & Bergin (1997), there is a "cultural demand for [spiritually-oriented] psychotherapists" (p. 6) who are able to centralize spiritual strategies in their work with people. These researchers suggest in their theistic spiritual perspective that "therapists [who] care deeply about their client's emotional and spiritual welfare, growth, and autonomy . . . can create a climate and therapeutic relationship that is emotionally and spiritually healing" (p. 139). The same ethic can be applied to recovery strategies whether through professional treatment for alcohol and substance abuse or through religious and/or privately sponsored recovery groups. In the recovery community regarding the recovery from alcohol dependence and/or abuse, A.A. has become an apparent mainstay. However, there are many organizations that have emerged over the past 10 years or more, which promote methods for recovery in addition to and other than an A.A. approach such as found in privately-owned therapeutic treatment facilities (e.g., therapeutic community viewpoint, Smart Recovery, Inc.) and/or through nationally sponsored programs. Yet the trend toward incorporating some kind of spirituality into treatment for alcohol dependence and/or abuse continues to be of importance for people committed to recovery. The emergent theme of the transcendent self has much relevance in the lived experience of the women co-researchers in this study regarding the construction of the self-identity as a *recovered* self.

The second theme the *transcendent self* is closely related to the first. For coming to see their lives from a recovered perspective they remove their point of view from a mundane perspective (living within experience) to being able to see from a *higher*, control view literally to transcend the mundane to *overview* from a position in which *directing* becomes possible.

Overview of Thematic Descriptors of Addictive Health Behavior

In the process of distilling themes from the narrative capta from the coresearchers' stories, several descriptive consistencies that were not necessarily thematic were noted as being significant to alcohol dependence and/or abuse. These consistencies among the coresearchers' shared experiences relate directly to the construction of alcohol dependence and/or abuse in a person's life. However, these thematic descriptives do not support a view of long-term maintenance of recovery from alcohol problems, but are worthy of a brief exploration of interpretive understanding regarding the construction of abusive patterns of alcohol addiction.

The co-researchers selected for this study were women who had maintained long-term recovery from alcohol problems. The first descriptive consistency was the notion of drinking alcohol at an early age. These women began their abusive drinking careers very early in childhood even as early as the age of 10 in one of co-researchers. But the average age was middle adolescence. Several of the co-researchers mentioned that by the time they were approximately 16 years of age they were already alcohol dependent. This finding in a qualitative study with a very small sample size cannot offer any conclusive

evaluations other than to note the consistency of shared experience among the co-researcher as important for future research.

The second descriptive consistency was the incidence of childhood and/or spousal abuse in the shared experience of the co-researchers. The co-researchers told stories of early emotional, physical, and sexual abuse as well as spousal abuse. This finding in the descriptive consistency among the shared experiences of the women in this study is consistent with other research findings in regard to survivors of child abuse who develop a substance abuse problem later in life (Evans & Sullivan, 1995). A point of connection can be drawn in this regard for a construction of survivorship as these women actually have had something traumatic in their shared experience from which to survive.

Lastly, a Native American cultural relationship with alcohol was noted in the descriptive consistencies among the co-researchers stories. This finding is an intriguing one in that it completely took me by surprise in the process of collecting demographic information from the co-researchers. Five out of seven women co-researchers self-disclosed the information that they had Native American ancestry in their heritage. This was an emergent consistency, in fact, two of these women self-described as being "Caucasian" women, but upon a follow-up interview with them they mentioned that they too had the strong possibility of Native American roots. Again, these descriptive consistencies among the co-researchers can serve to direct our attention toward additional research specifically designed to address this cultural connection to alcohol dependence and/or abuse. However, there is no ground for suggesting that this cultural pattern in the descriptive consistencies is anymore than coincidental.

Summary & Conclusion of Narrative Analysis

Narrative analysis is a method used to explore shared meanings in the lived experience among co-researchers' narratives. Narrative methodology employs Kvale's (1996) idea of "craftsmanship" in that a narrative interview researcher systematically constructs a story from the authentic stories of the co-researchers while paying attention to his or her interpretations throughout the entire process from interview through analysis. In this regard, effective narrative analysis has a built in validation process of "continual checks on the credibility, plausibility and trustworthiness of findings" (Kvale, 1996, p. 242).

As part of the process of analyzing the capta from the narrative interviews of the co-researchers, three *a priori* models of health behavior, which had been utilized in my pilot study regarding readiness for health behavior change, were contrasted with the model of the emergent self (Richey, 2003, figure 4.1). My work in regard to modeling the social construction of the emergent self and/or the recovered self allows for an in-depth understanding of how people continuously construct their self-identity, here, within context to a specific behavior. The process of identity construction is embedded within a physical and sociocultural environment, interactively mediated through intersubjective communication represented in this model as occurring in the intersections of the three systems of self: (a) the experiential self, (b) the relational self, and (c) the cultural self. This modeling of the emergent self represents an innovative way to visualize and understand the process of social construction as it relates to identity construction. Other health behavior models fall short when attempting to fully describe the transformational

processes inherent in identity construction, primarily because they do not recognize the constitutive centrality of communicative human nature. As human beings, we are ever-interpreting our realities, our physical, social, relational, and cultural worlds. And in the process, we construct an emergent self based upon our interactions with others and our intersubjective interpretations.

Secondly, two emergent themes derived from the co-researchers' stories of recovery: (a) Survivorship, and (b) the Transcendent Self were discussed in context to shared meaning as they relate to the social construction of the emergent, recovered self. The emergent themes represent the reconstruction, in constitutive interpretations, of a woman's self-identity as *the recovered self.* The process of recovery from alcohol dependence and/or abuse constitutes a uniquely personal and culturally specific journey for women. A recovered lifestyle is a completely different way of being for the woman who had previously been immersed in a culture of alcohol addiction—she now must construct a healthy self. A woman's process of recovery from alcohol addiction cannot be separated from the world of social/cultural/gender interactions in the construction of a healthier lifestyle. Whether a recovering person's social interactions are with professionals or are everyday interpersonal exchanges with intimates and others, they form the context within which the discursive evolution of identity is embedded. The narrative stories of the lived world of women in Alaska who are maintaining long-term recovery from alcohol problems provide an understanding of cultural, ethnic, and gender influences, various treatment and recovery paradigms, relational tensions, and the process of identity construction in the maintenance of ongoing recovery.

Research Limitations & Implications for Future Research

The limitations in this study partly relate to the nature of narrative interview research. First, the sample size for co-researchers is comparatively small in regard to other forms of research. The findings from this type of research are not intended to be generalized to a population, but promote an in-depth understanding of a particular lived experience such as recovery from alcohol dependence and/or abuse. Secondly, due to the emergent quality of being human, three co-researchers were dropped from the study. Considerable time and energy had been spent interviewing these participants. While the length of time allotted for this research study did not allow for interviewing new, potential co- researchers many others self-presented along the way. Although, Merleau-Ponty (1962) substantiates research of a single co-researcher, the focus on 15 remains a current aspect of narrative convention. Another consideration regarding a limitation of this study is in reference to the research context of alcohol dependence and/or abuse. Alcohol dependence and/or abuse tend to be sensitive subjects for people who have had alcohol problems. Often there is a social stigma attached to people who have suffered from addictions such as alcohol dependence and/or abuse. In the process of conducting research utilizing this context, I took extra time and deliberate precaution to be sensitive to my co-researchers' needs for privacy as well as for their free self-expression on the topic. If I were to design another research study regarding alcohol dependence/abuse, I would choose less ambiguous definitions for the constructs in the study. This factor suited the nature of my research inquiry needs, but tended to confuse some of the co-researchers, especially those who equate recovery from alcohol abuse with total

abstinence from the substance. Also, in regard to research audience, there are people who might criticize my inclusion of one co-researcher who stopped abusing alcohol, but who intermittently drinks small amounts of alcohol. The A.A. (1976) version of "continuous recovery" is purposely discounted in this work. There may be a potential criticism regarding the study's validity in that regard. Finally, a potential limitation of this kind of research relates to the quality of the co-researchers' capacity to share very personal information and the quality of "craftsmanship" (Kvale, 1996) the researcher employs in the process. The interview process is an interactive environment that requires focus and commitment from both the researcher and the co-researcher. The quality of the production of knowledge from narrative interview research relies upon the researcher to present a thoughtful and sensitive portrayal of lived experience and lived meaning. My voice and my biases are part of the research process. In this respect, my own attitude (no matter what it is) toward people who are alcohol dependent and/or who abuse alcohol may, in terms of their perceptions, serve to limit my co-researchers' responses.

Implications from this research on recovery from addiction to alcohol can be applied cross-culturally to people who suffer from other addictive/compulsive behaviors such as drug addiction, overeating, and compulsive gambling. Recovery from addiction seems to follow a similar course in most people in that there is a potential 50 percent relapse rate. In this regard, the modeling of the social construction of the emergent self becomes more relevant as a means of understanding other forms of addiction or other types of health behavior. In fact, this model has been applied to identity construction in cancer survivorship (O'Hair et al. study, in press). In addition, the constructs in the

emergent self model can be utilized in designing more effective health communication messages in health campaigns and/or more effectively target specific health behavior interventions because cultural and relational aspects of people's lives are central to understanding a person's identity construction.

The wealth of narrative information gleaned from the lived experiences of women who have suffered from alcohol dependence and/or abuse and who have maintained long-term recovery can be applied to other research studies designed to explore specific issues such as represented by the descriptive consistencies found in the shared experiences of the women in this study. A future study utilizing survey methodology regarding early drinking age and the development of alcohol dependence and/or abuse could potentially yield informative and revealing data about adult alcohol dependence and/or abuse, maternal consumption of alcohol, as well as a range of at-risk behaviors. The State of Alaska's Healthy People 2010 campaign already addresses some of these research inquiries. However, ongoing research targeted to study specific populations such as adolescent, binge-drinking behavior in Alaska, early adolescent pregnancy, and at-risk behaviors in adolescents can be effectively applied to preventative strategies taught in Alaska's public school system. Additionally, a future study derived directly from the descriptive consistencies from this research could explore issues of child abuse, domestic and partner abuse in connection with alcohol dependence and/or abuse. Another significant matter that presents itself from this research is the concept of spirituality in conjunction with recovery. Future research may well find that transcendent concepts, in relation to the emergent self, may be an avenue that can open new therapies particularly

for persons whose cultural background supports spirituality in some significant form (religion, karma, etc.).

Finally, the emergent research descriptive consistency of a Native American racial and ethnic background in relationship to chronic alcohol dependence and/or abuse deserves exploratory research to determine the prevalence of alcohol dependence and /or abuse in that particular population compared to other populations in the U.S and Canada. A narrative research design cannot generalize to any population, but the emergent consistency evident in this study is worthy of future scientific inquiry. This emergent finding intrigued the co-researchers who have Native American ancestry. Two co-researchers in particular may have been stimulated to research deeper into their family background to unearth a potential family secret. A research design involving survey methodology could collect relevant data for a quantitative statistical analysis.

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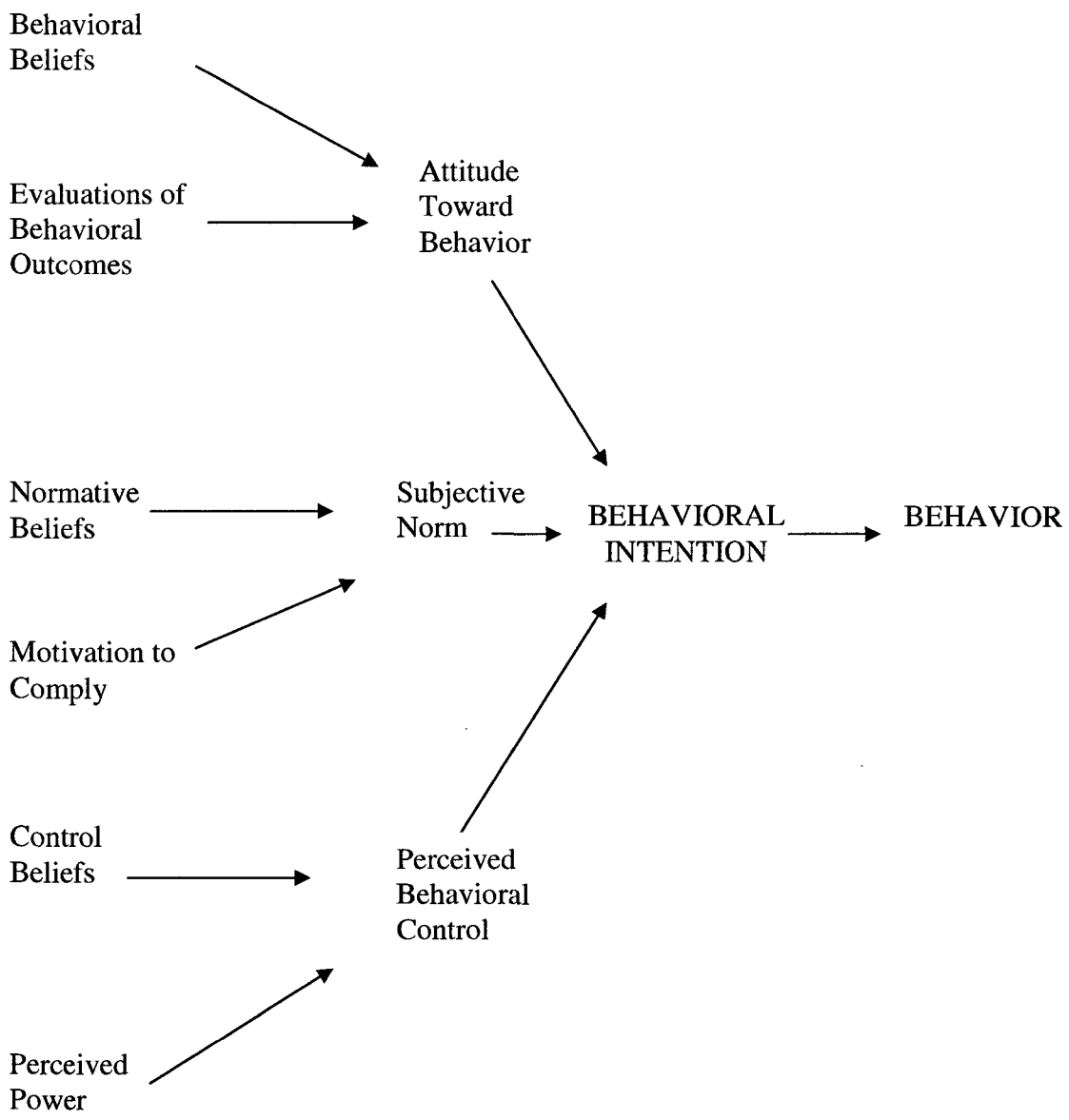
FIGURE 2.1

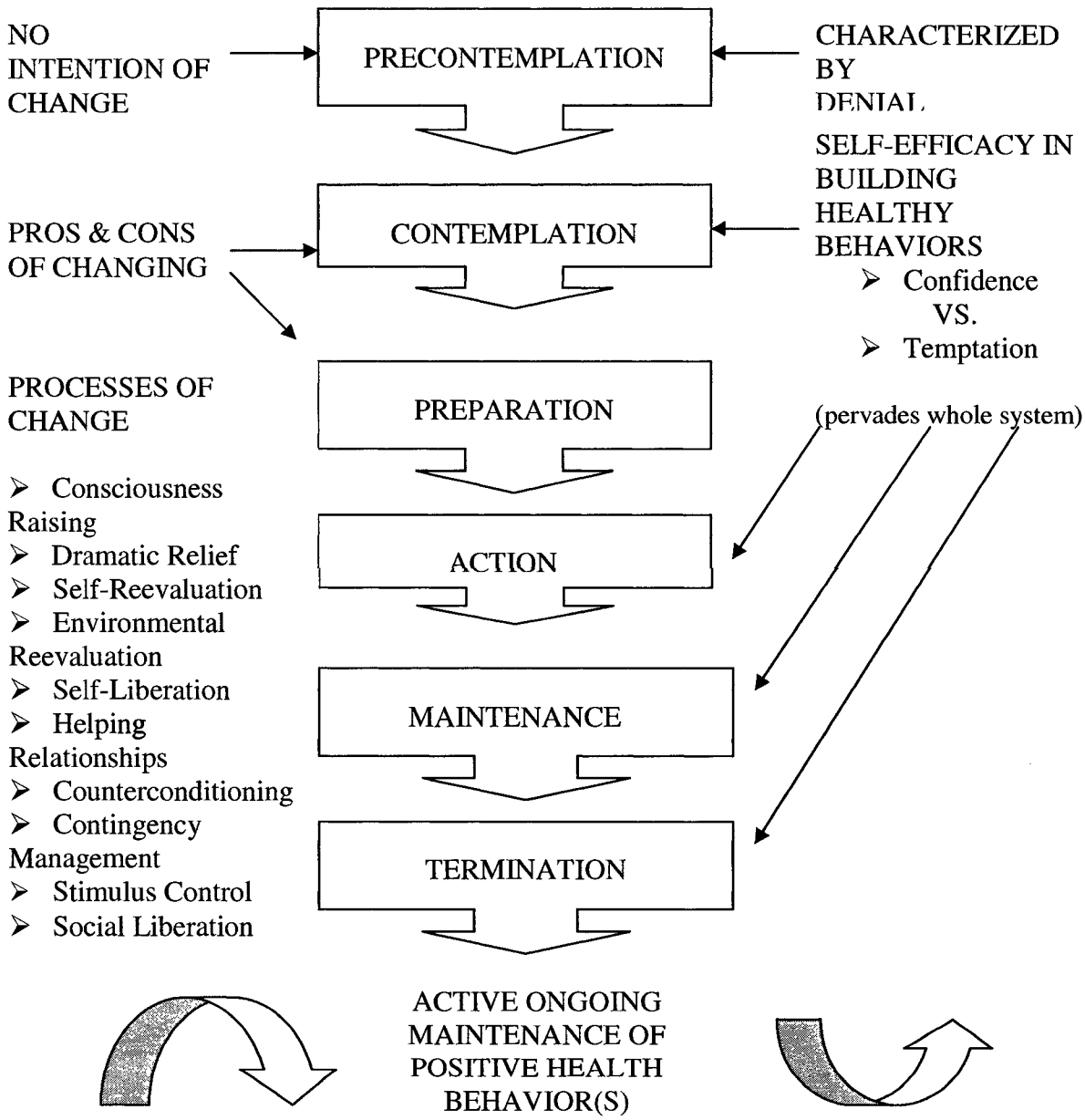
Theory of Reasoned Action and Planned Behavior



(Ajzen, 1991, 1996, 2001; Ajzen & Fishbein, 1980, 2000; Ajzen & Sexton, 1999; Fishbein, 1990; Fishbein & Ajzen, 1975)

FIGURE 2.2

Transtheoretical Model and Stages of Change



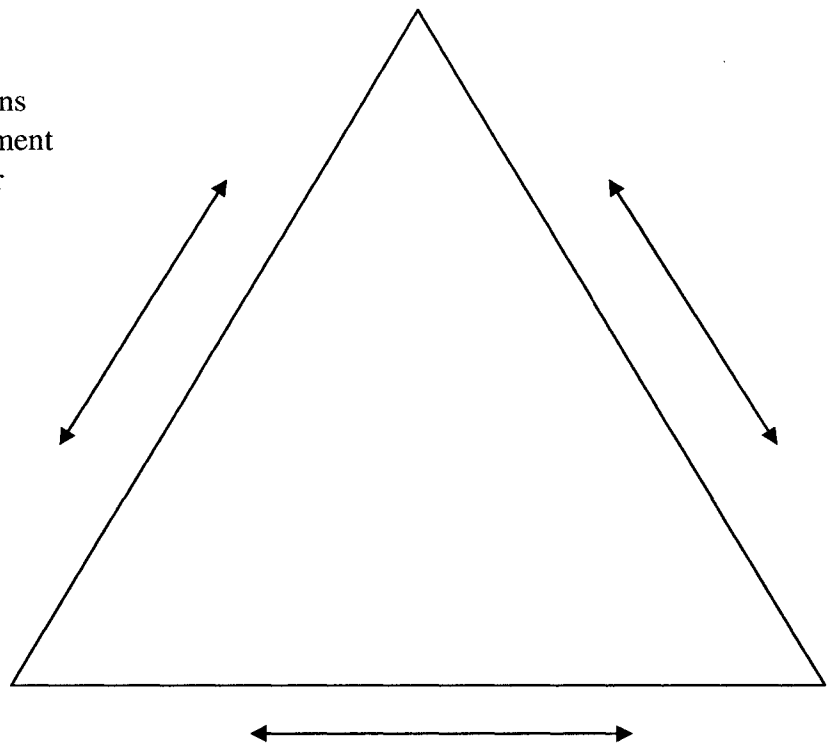
(DiClemente, 1999a; DiClemente & Hughes, 1990; DiClemente & Prochaska, 1998; Prochaska, 1984; Prochaska & DiClemente, 1983; Prochaska, DiClemente, & Norcross, 1992; Prochaska, Norcross, & DiClemente, 2002; Prochaska, Redding, & Evers, 1997)

FIGURE 2.3

Social Cognitive Theory – Triadic Reciprocality

Reciprocal Interaction Between

- Cognitions
- Environment
- Behavior



Emotional support

- family & friends
- group involvement such as A.A., group therapy, church, or team sports and activities increases self-confidence & self-efficacy

When we think about certain positive health behaviors

- We are more likely to enact them in our daily lives.

When we seek positive social support in our daily environment

- We are more likely to think about ourselves & our abilities in a positive way, which in turn can lead to positive sustaining relationships and healthy behaviors.

(Bandura, 1986, 1989, 1997, 2001)

APPENDIX A

Informed Consent Form

The goal of this research study is to explore the experiences of women in long-term recovery from alcohol dependence and/or abuse. Long-term is defined as five years or longer for the purposes of this study. This research project is being conducted by Jean Richey to be used as her dissertation project at the University of Alaska Fairbanks.

You are being asked to discuss your experiences during recovery from alcohol dependence in an interview with the researcher. There are approximately nine women being interviewed for this project. The interview will take approximately sixty to ninety minutes. Your story will be recorded on audiotape for transcription and study. The tapes will be destroyed as soon as the research project is complete. Your interview data will be assigned a different name during transcription in order to maintain your anonymity. Occasionally, you may experience uncomfortable feelings and emotions while discussing your experiences. If this happens, I encourage you to talk about your feelings with family or friends, a therapist, and/or attend an A.A. meeting. You are also being given a list of helpful resources that you may contact if you choose.

There will be no direct benefit to you, but your experiences may help others understand the recovery process. Your participation in the study is entirely voluntary and you may stop at any time. There will be no penalty to you if you withdraw from this study. If any question makes you uncomfortable, you do not have to answer it. Your name will not be used in any report or paper. A pseudonym (different name) will be used for the narrative story from your interview.

By reading and signing this form, you agree to participate in this study and understand the information listed above:

SIGNATURE: _____

NAME:_____ Date:_____

RESEACHER:_____Date:_____

Thank you for your interest and participation in the research project. You will be given a copy of this consent form and a copy of the research results will be mailed to you at your request

If you have any questions regarding your rights as a research subject, please contact Karin Davidson, Research Committee Coordinator, UAF Office of Research Integrity at 474-7800 or k.davidson@uaf.edu.

If you have any questions regarding this study please contact me and/or my advisor at:

Jean Richey, M.A.	Dr. Jin Brown	Office: 503 Gruening
474-1876	474-6818	Department of Communication,
ftjar@uaf.edu	ffjgb@uaf.edu	University of Alaska Fairbanks

APPENDIX B

Websites for Federal Government Agencies/Information on Alcohol & Substance Abuse

Center for Substance Abuse Treatment (CSAT)
http://www.samhsa.gov/centers/csat/csat.html

Department of Transportation - http://www.dot.gov/ost/dapc/
For printed DOT information on SAPs, please call 1-800-225-3784

- National Highway Traffic Safety Administration Impaired Driving Program Setting limits, Saving Lives, Myths about .08 Blood Alcohol (BAC) – http://www.nhtsa.dot.gov/people/injury/alcohol

Department of Health and Human Services - http://www.os.dhhs.gov/

National Clearinghouse for Alcohol and Drug Information - http://www.health.org/

National Institute on Alcohol Abuse and Alcohol dependence and/or abuse(NIAAA) - http://www.niaaa.nih.gov/

Association for Health Services Research's FrontLines Newsletter, Linking Alcohol Services Research and Practice - http://www.ahsr.org/publications/

2000 Senator Harold Hughes Award - http://www.rowsciences.com/haroldhughes/

National Center for Injury Prevention and Control –
http://www.cdc.gov/ncipc/factsheets/driving.htm
-Impaired Driving Fact Sheet

National Institute on Drug Abuse (NIDA) - http://www.nida.nih.gov/

- Community Drug Alert- http://www.drugabuse.gov/StressAlert/StressAlert.html
- Stress and Substance Abuse: A Special Report - http://www.nida.nih.gov/stressanddrugabuse.html
- Studies Link Stress & Drug addiction - http://www.nida.nih.gov/NIDA_Notes/NNVol14N1/Stress.html
- MEDLINEplus Health Information: Substance Abuse Topics - http://www.nlm.nih.gov/medlineplus/substanceabuse.html
- MEDLINEplus Health Information: Pregnancy and Substance Abuse - http://www.nlm.nih.gov/medlineplus/pregnancyandsubstanceabuse.html
- MEDLINEplus Health Information: Alcohol dependence and/or abuse- http://www.nlm.nih.gov/medlineplus/dependence and/or abuse.html

Appendix B Continued – B2

National Institutes of Health - http://www.nih.gov/

National Library of Medicine - http://www.nlm.nih.gov/

National Mental Health Association – http://www.nmha.org/

Office of National Drug Control Policy - http://www.whitehousedrugpolicy.gov/

Office of Juvenile Justice and Delinquency Prevention - http://ojjdp.ncjrs.org/

Substance Abuse and Mental Health Services Administration (SAMHSA) - http://www.samhsa.gov/
National Alcohol or Drug Treatment, Treatment Certification, Prevention or Research Organizations

American Association of Suicidology - http://www.suicidology.org/ - http://www.suicidology.org/index.html

Join Together Online - http://www.jointogether.org/home/
-sign up for JTO Direct, Daily Edition – a free service of JoinTogether – sends top stories on substance abuse directly to your email address.

Joint Commission on Accreditation of Healthcare Organizations (JCAHO) - http://www.jcaho.org/

National Association for Children of Alcohol addicted persons - http://www.nacoa.net/

National Association of State Alcohol and Drug Abuse Directors - http://www.nasadad.org/

National Council on Alcohol dependence and/or abuse and Drug Dependence (NCADD) - http://www.ncadd.org/

The Recovery Network – http://www.recoverynetwork.com/

Therapeutic Communities of America - http://www.tcanet.org/

Appendix B Continued – B3

Alcohol or drug addiction treatment resources and other information.

About – http://dependence and/or abuse.about.com

ADE Incorporated (Software Solutions for Human Problems) - http://www.adeincorp.com/

Addiction Search researched-based websites and documents - http://www.addictionsearch.com/addictionsearch/

Addiction Resource Guide - http://www.hubplace.com/addictions/

Addiction Technology Transfer Center Program - http://www.nattc.org/

Alchemy Project, based in the United Kingdom (resources) - http://www.alchemyproject.net/

Alliance Project - http://www.defeataddiction.org/

Alcohol and Drug Abuse – http://www.alcoholanddrugabuse.com

Alcohol and Drug Abuse Institute – http://depts.washington.edu/adai/

Alcohol and Substance Abuse – http://software2.bu.edu/COHIS/subabuse/subabuse.htm

Alcohol Epidemiology Program (research) - http://www.epi.umn.edu/alcohol/about/default.html
A Life Worth Living – http://www.arneson.net

Alternatives in Treatment - http://www.drughelp.com/

American Society of Addiction Medicine - http://www.asam.org/

AmIAnAddict – http://amianaddict.com/

Behavioral Health World for Professionals
(Substance Abuse and Related Mental Disorders) - http://bhworld.com/nonmember_home3.cfm?CFID=396811&CFTOKEN=43980173

The Betty Ford Center - http://www.bettyfordcenter.org/

Care Computer - http://www.carecomputer.com/

Appendix B Continued – B4

The Caron Foundation - http://www.caron.org/

Chemically Dependent Anonymous - http://www.cdaweb.org/

College Drinking Prevention – Taskforce – http://www.collegedrinkingprevention.gov

Connect For Kids – http://www.connectforkids.org/

Distance Learning Center for Addiction Studies - http://www.dlcas.com/

The Dual Diagnosis Website - http://users.erols.com/ksciacca/

Free virtual library with over 55,000 links - http://www.nyu.edu/socialwork/wwwrsw/

Gay/Lesbian/Bi/Trans*N.A. – http://glweb.com/glna/

GWC Incorporated provides education, training and materials on alcohol dependence and/or abuse& drug Abuse - http://www.gwcinc.com/

Getting Them Sober.com – http://GettingThemSober.com/

Hazelden (12-Step literature and products)- http://www.hazelden.org/
http://www.hazeldenbookplace.org/serenitynow/

Higher Education Center for Alcohol and Other Drug Prevention resource for colleges and universities seeking to reduce alcohol and other drug use. - http://www.edc.org/hec/

The Intervention Center - http://www.intervention.com/

JACS - Jewish alcohol addicted persons, addicts, family & friends working together to deal with the problem of addiction – http://www.jacsweb.org/

Life Esteem – http://lifeesteem.org/
http://lifeesteem.org/wellness/
NAADAC, The Association for Addiction Professionals – http://naadac.org/

Not My Kid, a site for parents who have concerns about their kids -
http://www.notmykid.org/

NYU World Wide Web Resources for Social Workers provides direct links to full text professionally relevant documents. - http://www.nyu.edu/socialwork/wwwrsw/

Appendix B Continued – B5

Open Mind – Substance Abuse and Chemical Dependency Resources Guide – http://open-mind.org/

Manisses Communications Group, Inc. - http://www.manisses.com/

ResearchNet, interactive collection of links groups by category - http://www.gwctrainingnetwork.com/researchnet.htm

Self Help Warehouse – http://www.selfhelpwarehouse.com/

Sierra Tucson - http://www.sierratucson.com/

SMART Recovery – http://www.smartrecovery.org/

Soberhouses.com - http://www.soberhouses.com/

SoberRecovery.com – http://www.soberrecovery.com/

Sober Times.com – Dedicated to Sobriety – http://sobertimes.com

Strengthening Families Program – http://www.strengtheningfamiliesprogram.org/

Substance Abuse Resource Center – http://www.rwjf.org/app/rw_substance_abuse/rw_res_sa_main.jsp

Talbott Recovery Campus - http://www.talbottcampus.com/

The North Carolina Foundation for Alcohol and Drug Studies - http://www.ncfads.org/indexn.html

Treatment Programs (comprehensive list of treatment facilities in the U.S.) - http://www.treatmentprograms.com/

Virginia Association for Marriage and Family Therapy - http://www.vamft.org/

University of Evansville Center for Continuing Education - http://www2.evansville.edu/cceweb/noncred/ceuprograms/index.htm

Web of Addictions - http://www.well.com/user/woa/

Women for Sobriety, Inc. – http://www.womenforsobriety.org

Appendix B Continued – B6

Alice - Go Ask Alice, Columbia University Health Sciences - http://www.alice.columbia.edu/

ARF - Addiction Research Foundation - http://www.arf.org/

CDC - Centers for Disease Control and Prevention - http://www.cdc.gov/health/diseases.htm

CESAR - Center for Substance Abuse Research , University of Maryland

DEA- Drug Enforcement Administration (DEA) - http://www.usdoj.gov/dea/index.htm

FF/AACAP - Facts for Families. American Academy of Child and Adolescent Psychiatry - http://www.aacap.org/

IPRC - Indiana Prevention Resource Center - http://www.drugs.indiana.edu/

IUDIC - Indiana University Alcohol and Drug Information Center - http://campuslife.indiana.edu/ADIC/

IAS - Institute of Alcohol Studies - http://www.ias.org.uk/

MoDADA - Missouri Division of Alcohol and Drug Abuse

MSB- Medical Sciences Bulletin -

NCI- National Cancer Institute - http://www.nci.nih.gov/

NFIA - National Families in Action - http://www.emory.edu/NFIA/

Oncolink - Oncolink at the University of Pennsylvania - http://oncolink.upenn.edu:80/

UICC - University of Illinois Counseling Center –

UMH - University of Montana HEALTHLINE -

VATTC - Virginia Addiction Technology Transfer Center - http://views.vcu.edu/vattc/

WHO - World Health Organization - http://www.who.int/home-page/

Appendix B Continued – B7

Other sites - alcohol addiction & health.

Al-Anon/Alateen – http://www.al-anon.alateen.org

Alaskafamily.org - http://www.alaskafamily.org/

Alaska Prevention Partnership – http://www.alaskaprevention.org/ - search engine for prevention and treatment programs for alcohol and drug abuse and dependence in Alaska.

Alaska Federation of Natives (AFN) Implementation Study: Proposals to the United States Congress to implement recommendations of the Alaska Natives Commission pursuant to P.L. 104-270 - http://www.alaskool.org/resources/ANC2/afn_implementation/afn_implementation.html

Alaska Native Commission Final Report Vol. I.– http://www.alaskool.org/resources/anc/anc_toc.htm

Alaska Native Commission Final Report Vol. II- http://www.alaskool.org/resources/anc2/anc2_toc.html

Alaska Native Commission Final Report Vol. III- http://www.alaskool.org/resources/anc/anc05.htm

Alaska State Legislature statutes - http://www.legis.state.ak.us/folhome.htm

Alcohol Screening.org - http://www.alcoholscreening.org/learnMore/index.asp

Alcohol addicted persons Anonymous - http://www.alcohol addicted persons-anonymous.org/

American Council on Alcohol dependence and/or abuse– ACA - http://www.aca-usa.org/

American Psychological Association (APA) Help Center - http://helping.apa.org/index.html

Canadian Mental Health Association (CMHA) Pamphlet Series: Stress - http://www.cmha.ca/english/store/mh_pamphlets/mh_pamphlet_07.htm

Center for Alcohol and Addiction Studies (CAAS), University of Alaska Anchorage - http://ichs.uaa.alaska.edu/caas/main.html

Appendix B Continued – B8

Chronic Disease Prevention (CDC) - http://www.cdc.gov/nccdphp/

Circles of Care Project (COC), University of Alaska Fairbanks - http://www.uaf.edu/psych/COC/COC_Substance_Abuse.htm

CRISP (Computer Retrieval of Information on Scientific Projects) - https://www-commons.cit.nih.gov/crisp/

is a searchable database of federally funded biomedical research projects conducted at universities, hospitals, and other research institutions. The database, maintained by the Office of Extramural Research at the National Institutes of Health, includes projects funded by the National Institutes of Health (NIH), Substance Abuse and Mental Health Services (SAMHSA), Health Resources and Services Administration (HRSA), Food and Drug Administration (FDA), Centers for Disease Control and Prevention (CDCP), Agency for Health Care Research and Quality (AHRQ), and Office of Assistant Secretary of Health (OASH).

Healthy People 2010 - http://web.health.gov/healthypeople/

Health Recovery Center (HRC) - http://www.healthrecovery.com/ - An approach to treatment and healing based on achieving biochemical balance, without pharmaceutical drugs.
AlcoholMD - Alcohol Abuse and Alcohol dependence and/or abuse Prevention, Treatment, and Recovery
http://www.alcoholmd.com/
Indiana University Health Center: Stress Management - http://www.indiana.edu/~health/stres.html

Institute for Circumpolar Health Studies (ICHS), University of Alaska Anchorage - http://ichs.uaa.alaska.edu/ichs/main.html

InteliHealth (Harvard Medical Schools Consumer Health Information - http://www.InteliHealth.com/

National Center for Health Statistics (NCHS) - http://www.cdc.gov/nchs/

State of Alaska, Advisory Board on Alcohol dependence and/or abuse and Drug Abuse (ABADA) - http://www.abada.com/

State of Alaska, Health & Social Services (DHSS), Division of Alcohol dependence and/or abuse and Drug Abuse (DADA) - http://www.hss.state.ak.us/dada/

Appendix B Continued – B9

State of Alaska DHSS, Fetal Alcohol Syndrome Website – http://www.hss.state.ak.us/fas/

State of Alaska, Health & Social Services, Section of Epidemiology – http://www.epi.hss.state.ak.us/publications.shtml

National AHEC Organization: Alaska Center for Rural Health - http://www.nationalahec.org/states.asp?state=AK

The RADACT Program (The Regional Alcohol and Drug Abuse Counselor Training) - http://www.radact.com/

Tanana Chiefs Conference, Inc. - http://www.tananachiefs.org/

Women and Children's Center for Inner Healing (WCCIH), Ralph Perdue Center (RPC), Fairbanks Alaska - http://www.ptialaska.net/~fnawcp/web/

(compiled by Richey, 2003)

APPENDIX C

Prevention & Treatment Centers In Alaska

Approved Treatment Facilities in Alaska

State of Alaska Directory of Approved Alcohol Dependence and/or Abuse and Drug Abuse Programs - published annually by the Division of Alcohol Dependence and/or Abuse and Drug Abuse (DADA)
(highlighted in gray) – Revised January 2002

ALAKANUK
AVCP Inc Youth Opportunity Grant
PO Box 149
Alakanuk, AK, 99554
Phone: 907-238-3945; Fax: 907-238-3949
Email: bogirl@unicom-alaska.com

ALLAKAKET
Allakaket Counseling Center
P.O. Box 89
Allakaket, AK 99720
Phone: 907-968-2210; Fax: 907-968-2288
Available Services: Outpatient Care, Aftercare, Prevention Outreach

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ANCHORAGE
Akeela House -Wildwood RSAT -Palmer ISAT -Seward ISAT -Point McKenzie ISAT -Bethel ISAT
4111 Minnesota Drive
Anchorage, AK, 99503
Phone: 907 565-1200; Fax: 907 258-6052
Email: jsellers@akeela.org; Email: lryan@akeela.org -Prevention
Email: kathyboggsgray@akeela.org -Economic Interventions
Web site: http://www.akeela.org & http://www.alaskaprevention.org
Available services: Adult Res., Intermediate Care, Outpatient Care, Aftercare, Prevention

Alaska Commission for Chemical Dependency Professional Certification
1251 Muldoon Road, Suite 116
Anchorage, AK 99504
Phone: 907-332-4333; Fax: 907-332-4334
Email: certcom@alaska.net
Available Services: Certification

Appendix C Continued– C2

Alaska Division of Public Health, MCFH
1231 Gambell St
Anchorage, AK, 99501
Phone: 269-3425; Fax: 269-3432
Available Services: Prevention

Alaska Human Services (Private)
PO Box 230215
Anchorage, AK, 99523
Phone: 907 561-4535; Fax: 907 563-4534
Email: ahsral@alaska.net
Available services: Outpatient, Aftercare

AK Injury Prevention Center
Anchorage, AK
Phone: 907-929-3939; Email: tracysaak@hotmail.com
Web site: http://www.alaska-ipc.org
Available Services: Prevention

Alaska Women's Resource Center (AWRC) - New Dawn, Sage, Stepping Stones
PROGRAM CLOSING ITS DOORS MAY 2002
111 W. 9th Avenue
Anchorage, AK, 99501
Phone : 907-276-0528; Fax: 907 279-6754
Email: akwomens@ak.net OR awrc@ak.net
Available services: Women with Children Residential

Aleutian Pribolof Island Association, Inc.

201 E. 3rd Avenue
Anchorage, AK, 99501
Phone: 907 276-2700; Fax: 907 279-4351
Email: michelek@apiai.com
Available services: Adult Outpatient, Aftercare, Prevention, Outreach

Arc of Anchorage
2211 Arca Drive
Anchorage, AK, 99508
Phone: 907 338-3686
Phone: 907-277-6677; Fax: 907 272-2161
Email: wivy@arc-anchorage.org; Web: http://www.arc-anchorage.org
Available services: Intermediate Care, Outpatient, Aftercare

Appendix C Continued– C3

Anchorage Center for Families
3745 Community Park Loop, Ste.102
Anchorage, AK, 99508
Phone: 257-0305/1-888-701-0328; Fax: 276-6930
Email: prevention@acfonline.org

AHFC
4300 Boniface Parkway
Anchorage, AK,
Phone: 338-8418; Fax: 338-1683
Available Services: Prevention

Boys & Girls Clubs
Mountain view Clubhouse
Anchorage, AK, 99508
Phone: 297-5400; Fax: 297-5432
Available Services: Prevention

Chugachmiut, Inc.
4201 TudorCenter Drive, Suite 210
Anchorage, AK 99508
Available Services: Prevention
Phone: 907-562-4155; Fax: 907-563-2891
Email: shirley@chugachmiut.com
Available Services: Prevention

Eastern Aleutians Tribes, Inc.
1600 A Street, Suite 104
Anchorage, AK, 99501
Phone: 907 277-1440; Fax: 907 277-1446
Email: lcdevlin@gci.net
Available services: Adult Outpatient, Aftercare

Ernie Turner Center - Alaska North Addiction Recovery Center
4330 South Bragaw Street
Anchorage, AK, 99508
Phone: 907-561-5537 OR 800-478-4786; Fax: 907 562-7332
Email: nbushey@citci.com; Web site: http://www.ernieturner.com
Available services: Adult Residential, Intermediate Care, Aftercare

Appendix C Continued– C4

Genesis House, Inc. (Private)
2825 W. 42nd Place
Anchorage, AK, 99517
Phone: 907 243-5130; Fax: 907 248-8350
Available services: Outpatient, Intermediate Care, Aftercare

Health TV channel, Inc.
3820 Lake Otis Parkway
Anchorage, AK, 99508
Phone: 770-6200; Fax: 336-6205
Available Services: Prevention

Mt. View Boys & Girls
315 North Price Street
Anchorage, AK, 99508
Phone: 907-297-5416; Fax: 907-297-5432
Email: jalexander@mail.bgcalaska.org
Available Services: Prevention

Narcotic Drug Treatment Center
520 E. 4th Avenue Suite 102
Anchorage, AK, 99501
Phone: 907 276-6430; Fax: 907 276-3637
Email: ndtc@ak.net
Available services: Adult Outpatient, Methadone Treatment, Aftercare, Outreach

Pacific Rim Counseling – Anchorage
4141 B Street, Suite 210
Anchorage, AK, 99503
Phone: 907 561-5252; Fax: 907 563-5995
Email: pacrimco@alaska.net
Available services: Outpatient

Providence Breakthrough (Private)
2401 E. 42nd Avenue, Suite 103
Anchorage, AK, 99508
Phone: 907 562-7325 OR 800-478-0615; Fax: 907 562-6193
Email: dmarman@provak.org
Available services: Outpatient, Aftercare

Appendix C Continued– C5

Rational Insight Treatment Enterprises (R.I.T.E.) – Anchorage
301 E. Fireweed, Suite 102
Anchorage, AK, 99503
Phone: 907 562-7483; Fax: 907 561-3274
Email: rite@alaska.net
Available services: Outpatient, Aftercare

The Recovery Connection (Private)
1251 Muldoon Road, Suite 104B
Anchorage, AK 99524-1045
Phone: 907-332-7660; Fax: 907-332-7661
Available Services: Outpatient, Aftercare

Rural Community Action Program (CAP), Inc.
731 East 8th Avenue
P.O. Box 200908
Anchorage, AK, 99520
Phone: (907)-279-2511; Fax: (907)-278-2309
Email: marian@ruralcap.com
Available Services: Prevention

Salvation Army Booth Memorial
3600 E. 20th Avenue
Anchorage, AK, 99508
Phone: 907 279-0522; Fax: 907 279-5073
Email: booth@ak.net
Available services: Outpatient, Aftercare (Adolescents)

Salvation Army Clitheroe Center
1709 S. Bragaw, Suite B
P.O. Box 190567
Anchorage, AK, 99519
Phone: 907 276-2898; Fax: 907 279-8526
Email: sacc@alaska.net OR melinda@saccak.org
Available services: Adult Residential, Adult Outpatient, Emergency Care, Aftercare, Outreach

Service High School
Anchorage, AK
Phone: 907-346-2111/907-338-5659; Email: blakeneys@gci.net
Available Services: Prevention

Appendix C Continued– C6

Southcentral Foundation - Dena A. Coy
431 San Ernesto
Anchorage, AK, 99508
Phone: 907 729-5070; Fax: 907 729-5000
Email: kjohnson@citci.com; Web: http://www.ak-scf.org/serviceshuman_services.htm
Available services: Intermediate Care, Aftercare, Women with Children Residential, (Pregnant Women & Newborns)

Starting Point – Anchorage (Private)
341 W. Tudor, Suite 205
Anchorage, AK, 99503
Phone: 907 562-6116
Fax: 907 562-6350
Email: spa@alaska.net
Available services: Outpatient, Aftercare

Substance Abuse Directors Association
4111 Minnesota Dr.
Anchorage, AK, 99503
Phone: 907-770-2927; Fax: 907-258-6052
Available Services: Prevention

Volunteers of America of Alaska, Inc./ASSIST (& Youth Intervention Programs)
1675 C Street, Suite 201
Anchorage, AK, 99501
Phone: 907-279-9634; Fax: 907-276-5489
Email: assist@voaak.org
Available Services: Youth & Family Outpatient, Aftercare, Prevention, Outreach

Wayland Baptist University
PO Box 244572
Anchorage, AK, 99524
Phone: 907-248-7809; Email: paljr@pobox.alaska.net
Available Services: Prevention

ANDREAFSKY
Alaska Youth & Parent Foundation
Andreafsky, AK,
Phone: 907-257-8848; Fax: 907-277-2428
Available Services: Prevention

Appendix C Continued– C7

ANGOON
Community Family Services
SEARHC
P.O. Box 70
Angoon, AK 99820
Phone: 907- 788-3893/3636; Fax: 907-788-3179
Email: sharonmcindoo@searhc.org OR mack99820@yahoo.com
Web: http://www.searhc.org
Available Services: Outpatient, Aftercare, Prevention

ANIAK
Kuskokwim Native Association (KNA)
KNA Community Counseling Center
P.O. Box 155
Aniak, AK, 99557
Phone: (907)-675-4445 OR 800-478-5622; Fax: (907)-675-4456
Email: knaccc@arctic.net OR drandama@yahoo.com
Available services: Adult Outpatient, Aftercare

BARROW
North Slope Borough Counseling Service-SATS
P.O. Box 69
Barrow, AK 99723
Phone: 907-852-0366; Fax: 907-852-0315
Email: dkooley@co.north-slope.ak.us
Available services: Adult Residential, Adult Outpatient, Emergency Care, Intermediate Care, Aftercare, Outreach

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BETHEL
Bethel Group Home Inc.
P.O. Box 385
Bethel, AK 99559
Phone: 907-543-2846; Fax: 907-543-1912
Email: pjanowiec @bethelgrouphome.org
Available Services: Outpatient, Aftercare

Bethel VPS
PO Box 268
Bethel, AK, 99559
Phone: 907-543-2294

Appendix C Continued– C8

Yukon-Kuskokwim Health Corporation (YKHC) - Behavioral Health Services
PO Box 528
Bethel, AK, 99559
Phone: 907 543-6104; Fax: 907 543-6159
Email: sandy_mironov@ykhc.org; Web site: http://www.ykhc.org
Available service: Adult Outpatient, Aftercare, Prevention

Yukon-Kuskokwim Health Corporation (YKHC) - Family Spirit Project
PO Box 528
Bethel, AK, 99559
Phone: 907 543-6700; Fax: 907 543-6006
Email: raymond_watson@ykhc.org; Web site: http://www.ykhc.org
Available services: Outreach, Prevention

Yukon-Kuskokwim Health Corporation (YKHC)
Phillips Ayagnirvik Treatment Center
PO Box 528
Bethel, AK, 99559
Phone: 907 543-6735; Fax: 907 543-6712
Email: mike_bricker@ykhc.org; Web site: http://www.ykhc.org
Available services: Intermediate Care, Aftercare

CHEVAK
Coastal Villages
Chevak, AK,
Phone: 858-7250; Fax: 858-7692

COLD BAY
Eastern Aleutian Tribes, Inc.
P.O. Box 67
Cold Bay, AK 99571
Phone: 907-532-2585; Fax: 907-532-2001
Email: eskansq@gci.net
Available Services: Outpatient, Aftercare

COPPER CENTER
Native Village of Kluti Kaah
P.O. Box 68
Copper Center, AK, 99573
Phone: (907)-822-5541; Fax: (907)-822-3662
Email: clarence@alaska.net

Appendix C Continued– C9

CORDOVA
Cordova Community Medical Center - Sound Alternatives
PO Box 160
Cordova, AK, 99574
Phone: 907 424-8300; Fax: 907 424-8645
Email: sound-alternatives@cdvcmc.com
Available services: Adult Outpatient, Aftercare, Prevention

CRAIG
Communities Organized for Health Options (COHO)
PO Box 805
Craig, AK, 99921
Phone: 907-826-3662; Fax: 907-826-2917
Email: coho@aptalaska.net
Available services: Adult Outpatient, Aftercare

DELTA JUNCTION
Delta Junction
P.O. Box 525
Delta Junction, AK, 99737
Phone: 895-4655
Available Services: Prevention

Family Centered Services
PO Box 346
Delta Junction, AK, 99767
Phone: 907-895-5083; Fax: 907-895-5078

DILLINGHAM
Bristol Bay Area Health Corporation
6000 Kanakanak Rd
P.O. Box 130
Dillingham, AK, 99576
Phone: 907-842-5201; Fax: 907-842-9354; Email: ctilden@bbahc.alaska.ihs.gov
Available Services: Adult Residential, Adult Outpatient, Intermediate Care, Women with Children Outpatient, Aftercare, Emergency Care, Outreach, Prevention/Education

Jake's Place, Kanakanak Hospital
PO Box 130
Dillingham, AK, 99576
Phone: 907-842-5266; Fax: 907-842-5915; Email: cmiller@bbahc.org
Available Services: Prevention

Appendix C Continued– C10

EAGLE RIVER
Starting Point- Eagle River (Private)
11823 Old Glenn Highway Suite 205
Eagle River, AK, 99577
Phone: 907 562-6116 ; Fax: 907 562-6117
Email: spa@alaska.net
Available services: Outpatient Care, Aftercare

Volunteers of America of Alaska/ARCH
HC 85, PO Box 9549
Mile-2, Highland Road
Eagle River, AK, 99577
Phone: 907 694-3336; Fax: 907 694-8840
Email: voaak2@mtaonline.net
Available services: Intermediate Care, Aftercare (Adolescents)

EGEGIK
City of Egegik
P.O. Box 189
Egegik, AK, 99579
Phone: 233-2202; Fax: 233-223; Email: rbonn2414@aol.com

EKLUTNA
Eklutna Village Council
26339 Eklutna Village Rd
Eklutna, AK, 99567
Phone: 688-6020; Fax: 688-6021

FAIRBANKS
Fairbanks Native Association (FNA) - Graf-Rheeneerhaahii
PO Box 80450
Fairbanks, AK, 99708
Phone: 907 455-4725; Fax: 907 455-4730; Email: grafhealing@gci.net
Available services: Intermediate Care (Adolescents)

Fairbanks Native Association (FNA) - Inroads to Healing
605 Hughes Avenue
Fairbanks, AK, 99701
Phone: (907)-451-1830; Fax: (907)-451-1835
Email: nstone@fairbanksnative.org
Available Services: Outpatient, Aftercare

Appendix C Continued– C11

Fairbanks Native Association (FNA) - Life Givers
605 Hughes Avenue
Fairbanks, AK, 99701
Phone: 907 452-1724; Fax: 907 452-4148
Email: fnalife2@mosquiotonet.com
Available services: Intermediate Care, Aftercare (Pregnant Adolescents) (Newborns)

Fairbanks Native Association (FNA) - New Hope Center – Domiciliary Care
3051 N. Vanhorn Road
Fairbanks, AK, 99701
Phone: 907 451-1170; Fax: 907 451-0962
Available services: Intermediate Care, Aftercare

\Fairbanks Native Association (FNA) - Ralph Perdue Center (RPC)
3100 South Cushman Street
PO Box 74450
Fairbanks, AK, 99707
Phone: 907 456-7819; Fax: 907 456-4849
Email: rperduecenter@mosquitonet.com
Available services: Emergency Care, Intermediate Care, Aftercare

Fairbanks Native Association (FNA) -Women & Children's Center for Inner Healing (WCCIH)
P.O. Box 71048
Fairbanks, AK, 99707
Phone: 907-451-8164; Fax: 907-451-0273
Email: fnawcrp@ptialaska.net; Web: http://www.ptialaska.net/~fnawcp/web
Available services: Intermediate Care, (Women & Children), Aftercare

Family Recovery Center (Private) - Fairbanks Memorial Hospital
1650 Cowles
Fairbanks, AK, 99701
Phone: 907 458-5540; Fax: 907 458-5541
Email: cdavilla@bannerhealth.com
Available services: Aftercare, Outpatient Care

FNA DFYS Program
PO Box 74450
Fairbanks, AK, 99707
Phone: 907 452-6251; Fax: 907 456-4849

Appendix C Continued– C12

Interior AIDS Association/Project Special Delivery
710 3rd Avenue
P.O. Box 71248
Fairbanks, AK, 99707
Phone: 907 452-4222; Fax: 907 452-8716
Email: iaageneral@alaska.com
Available services: Outpatient Care, Methadone Maintenance, Aftercare

Pacific Rim Counseling – Fairbanks (Private)
529 6th Avenue, Suite 200
Fairbanks, AK, 99701
Phone: 907 452-5252; Fax: 907 452-6233
Email: pacrimco@alaska.net
Available services: Outpatient Care, Aftercare

Tanana Chiefs Conference, Inc. (TCC) - Old Minto Family Recovery Camp
122 1st Avenue, Suite 600
Fairbanks, AK, 99701
Phone: 907-452-8251 ext. 3144 OR 800-478-6822; Fax: 907 459-3835
Email: vjoseph@tananachiefs.org
Available services: Intermediate Care, Aftercare

Tanana Chiefs Conference, Inc. (TCC)
Regional Prevention Program
201 1st Ave., Suite 300
Fairbanks, AK, 99701
Phone: (907)-452-8251 ext. 3166 OR 800-478-6822; Fax: (907)-459-3950
Email: mwilson@tananachiefs.org
Available Services: Prevention

Unloading Zone (Private)
542 4th Avenue, Suite 230
Fairbanks, AK, 99701
Phone: 907-452-2412; Fax: 907-451-7258
Email: unloadingzone@mindspring.com
Available services: Child & Adult Outpatient, Aftercare

Appendix C Continued– C13

Yukon-Tanana Counseling Service (TCC)
1302 21st Avenue
Fairbanks, AK, 99701
Phone: 907 459-3930; Fax: 907 459-3833
Email: dhojna@tananachiefs.org
Available services: Adult Outpatient

FORT YUKON
Yukon Flats Care Center- CATG
PO Box 21
Fort Yukon, AK, 99740
Phone: 907-662-2526; Fax: 907 766-2627
Available services: Prevention, Outpatient

GUSTAVUS
Gustavus Community Association
P.O. Box 116
Gustavus, AK, 99826
Phone: (907)-697-2282
Email: seahag@seaknet.alaska.edu

HAINES
Community Family Services
SEARHC
P.O. Box 69
Haines, AK 99827
Phone: 907-766-2959; Fax: 907-766-2680
Email: lkasko@searhc.org; Web: http://www.searhc.org
Available Services: Outpatient, Aftercare, Prevention

HEALY
Raibelt Mental Heatlh & Addictions
P.O. Box 128
Healy, AK 99743
Phone: 907-683-2743; Fax: 907: 683-2598
Email: rmha@mtaonline.com
Available Services: Outpatient, Aftercare, Outreach

Appendix C Continued– C14

HOMER
Choices for Teens, Inc.
P.O. Box 1013
Homer, AK, 99603
Phone: (907)-235-4991; Fax: (907)-235-7134
Email: cassie@alaska.net
Available Services: Prevention

Cook Inlet Council on Alcohol & Drug Abuse
P.O. Box 2352
Homer, AK 99603
Phone: 907-235-8001; Fax: 907-235-8099
Email: dalton@pobox.alaska.net
Available Services: Outpatient, Aftercare, Prevention

HOONAH
City of Hoonah, William & Mary Johnson Youth Center
PO Box 360
Hoonah, AK, 99829
Phone: 907-945-3780; Fax: 907-945-3450
Email: jayd99829@yahoo.com
Available Services: Prevention

Hoonah Indian Association
254 Roosevelt Street
P.O. Box 602
Hoonah, AK 99829-0602
Phone: 907-945-3545; Fax: 907-945-3703
Email: jdybd1111@aol.com
Available Services: Outpatient, Aftercare

HYDABURG
Community Family Services
SEARHC
P.O. Box 356
Hydaburg, AK 99922
Phone: 907-285-3465; Fax: 907-285-3802
Email: willie.shields@searhc.org; Web: http://www.search.org
Available Services: Outpatient, Aftercare, Prevention

Appendix C Continued– C15

JUNEAU
Big Brothers Big Sisters of Juneau
P.O. Box 20049
Juneau, AK, 99802
Phone: (907)-586-3350; Fax: (907)-586-1886
Email: bbbsj@alaska.net; Web: http://www.bbbsa.org
Available Services: Prevention

Gastineau Human Services - Gastineau Behavioral Health Program
5597 Aisek Street
Juneau, AK, 99801
Phone: 907 780-4338; Fax: 907 780-4098; Email: ghs@ptialaska.net
Available Services: Outpatient, Aftercare, Intermediate Care, And Residential Treatment Care

Juneau Recovery Hospital
3250 Hospital Drive
Juneau, AK, 99801
Phone: 907 586-9508 ext. 234; Fax: 907 586-5605;
Email: steve_sundby@mail.ci.juneau.us
Available services: Adult Residential, Adult, Outpatient, Aftercare, and Emergency Care

Juneau Youth Services, Inc.
P.O. Box 32839
Juneau, AK, 99803
Phone: 907-796-4137; Fax: 907-789-7655; Email: cindyb@jys.org
Available services: Outpatient, Aftercare (Adolescents)

National Council on Alcohol dependence and/or abuse & Drug Dependence (NCADD) - Juneau Affiliate
211 4th St., Suite 102
Juneau, AK, 99801
Phone: 907-463-3755 OR 463-4410 JSAP; Fax: 907-463-2539
Intervention Hotline Only: 907-586-4859 OR 800-654-4073; Email: ncaj@ptialaska.net
Available Services: Prevention, Consultation/Education

Tongass Community Counseling Center
222 Seward Street, Suite 202
Juneau, AK, 99801
Phone: 907 586-3585; Fax: 907 586-3241; Email: tcccjuno@ptialaska.net
Available services: Outpatient, Aftercare

Appendix C Continued– C16

KAKE
Community Family Services -SEARHC
P.O. Box 589
Kake, AK, 99830
Phone: 907-785-3895/4892; Fax: 907-785-3350
Email: daceveda@searhc/.org & ksmith@searhc.org; Web: http://www.searhc.org
Available Services: Outpatient, Aftercare, Prevention

KALTAG
City of Kaltag
P.O. Box 9
Kaltag, AK, 99748
Phone: (907)- 534-2220; Fax: (907)-534-2236
Email: vmburnham@aol.com

KENAI
Cook Inlet Council on Alcohol & Drug Abuse
PO Box 882
Kenai, AK, 99611
Phone: 907 283-3658 ext. 204; Fax: 907 283-5046; Email: cicada@alaska.net
Available services: Adult Outpatient, Aftercare

Kenaitze Indian Tribe IRA
PO Box 988
Kenai, AK, 99611
Phone: 907 283-6693; Fax: 907 283-7088; Email: nakenu@alaska.net
Available services: Outpatient, Aftercare (Adolescents)

Pacific Rim Counseling – Kenai
11355 Frontage Road, Suite 223
Kenai, AK, 99611
Phone: 907 283-3999; Fax: 907 5088
Email: pacrimco@alaska.net
Available services: Outpatient, Aftercare

The Recovery Connection (Private)
11355 Frontage Road, Suite 200B
Kenai, AK 99611
Phone: 907-335-5660
Available Services: Outpatient, Aftercare

Appendix C Continued– C17

KETCHIKAN
Gateway Center for Human Services - City of Ketchikan
3050 5th Avenue
Ketchikan, AK, 99901
Phone: 907 225-4135; Fax: 907 247-4135; Email: kevinm@city.ketchikan.ak.us
Available services: Emergency Care, Intermediate Care, Outpatient, Aftercare, Outreach

Ketchikan General Hospital (Private) - Alaskans for Drug Free Youth
3100 Tongass Avenue
Ketchikan, AK, 99901
Phone: 907 247-4330; Fax: 907 247-4293
Email: bhardy@peacehealth.org; Web: http://www.peacehealth.org
Available services: Outpatient, Aftercare, Medical Detox, Adult/Adolescent Care

Ketchikan Indian Corporation
2960 Tongass Avenue
Ketchikan, AK 99901
Phone: 907-225-4061; Fax: 907-247-4061; Email: dpatton@kictribe.org
Available Services: Prevention

KING COVE
Eastern Aleutian Tribes, Inc.
P.O. Box 206
King Cove, AK, 99612
Phone: 907-497-2342; Fax: 907-497-3110; Email: rong@gci.net
Available Services: Outpatient, Aftercare

KLAWOCK
Community Family Services - SEARHC
P.O. Box 69
Klawock, AK, 99925
Phone: 907-755-4800; Fax: 907-755-2993
Email: jay.badagliacca@searhc.org; Web: http://www.searhc.org
Available Services: Outpatient, Aftercare, and Prevention

KLUKWAN
Community Family Services - SEARHC
P.O. Box 690
Klukwan, AK, 99827
Phone: 907-767-5592; Fax: 907-767-5599
Email: jhotze@WytBear.com;Web: http://www.searhc.org
Available Services: Outpatient, Aftercare, and Prevention

Appendix C Continued– C18

KODIAK
Kodiak Council on - Safe Harbor
115 Mill Bay Rd.
Kodiak, AK, 99615
Phone: 907-486-3535; Fax: 907-486-7689; Email: safeharbor@gci.net
Available Services: Intermediate Care, Outpatient Care, and Aftercare

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KOTZEBUE
Maniilaq Addiction & Support Services
P.O. Box 256
Kotzebue, AK, 99752
Phone: (907)-442-7640; Fax: (907)-442-7822; Email: reunice@maniilaq.org
Available Services: Emergency Care, Intermediate Care, Aftercare, Outpatient Care, Outreach

Robert Aggaluk Newlin Sr. Memorial Trust
P.O. Box 509
Kotzebue, AK, 99752
Phone: (907)-442-3301; Fax: (907)-442-2289; Email: caleb_pungowiyi@nana.reg.com

NW Artic Borough
PO Box 1010
Kotzebue, AK, 99752
Phone: 800-478-1110
Available Services: Prevention

KWETHLUK
Kwethluk IRA Council
Box 129
Kwethluk, AK, 99621
Phone: (907)-757-6750; Fax: (907)-757-6328
Available Services: Prevention

MCGRATH
4 Rivers Counseling Service - McGrath-Anvik Educational & MH Association
P.O. Box 229
McGrath, AK, 99627
Phone: (907)-524-3781 or 800-478-3781; Fax: (907-524-3519
Email: mojowrkn@mcgrathalaska.net
Available Services: Emergency Care, Intermediate Care, Outpatient Care, Aftercare, and Prevention

Appendix C Continued– C19

MATANUSKA-SUSITNA BOROUGH
Mat Su Recovery Youth Facility
Matanuska-Susitna Borough
Phone: 907-746-1630; Fax: 907-761-7249

NAPASKIAK
Napaskiak Tribal Council
PO Box 6109
Napaskiak, AK, 99634
Available Services: Prevention

NENANA-PREVENTION & TREATMENT
Railbelt Mental Health & Addictions
PO Box 159
Nenana, AK, 99760
Phone: 907-832-5557; Fax: 907-832-5564
Email: rmha@mtaonline.net
Available services: Adult Outpatient, Aftercare

NOME
Nome Community Center
P.O. Box 98
Nome, AK, 99762
Phone: (907) 443-5259; Fax: (907) 443-2990
Email: nccdir@nook.net
Available Services: Prevention

Norton Sound Health Corporation - Norton Sound Behavioral Health Program
PO Box 966
Nome, AK, 99762
Phone: 907-443-3311; Fax: 907-443-3724
Email: franks@nshcorp.org
Available Services: Outpatient Care, Aftercare, Prevention

NULATO
Nulato Native Magistrate
PO Box 116
Nulato, AK, 99765
Phone: 907-898-2268

Appendix C Continued– C20

OLD HARBOR
Old Harbor Public Security Office
PO Box 74
Old Harbor, AK, 99643
Phone: 907-286-2275; Fax: 907-286-2275

PALMER
Carry the Cure
HC5 Box 9550 N
Palmer, AK, 99645
Phone: 907-745-8295; Email: humdrum@mtaonline.net
Available Services: Prevention

Starting Point – Palmer (Private)
415 S. Bailey Street, Suite B
Palmer, AK, 99645
Phone: 907-376-6116; Fax: 907-376-9193; Email: spa@alaska.net
Available services: Outpatient Care, Aftercare

PELICAN
Community Family Services - SEARHC
P.O. Box 703
Pelican, AK, 99832
Phone: 907-735-2278; Fax: 907-735-2550
Email: jay.brauch@searhc.org; Web: http://www.searhc.org
Available Services: Outpatient, Aftercare, Prevention, Outreach

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PETERSBURG
Changing Tides Counseling Services
PO Box 1350
Petersburg, AK, 99833
Phone: 907-772-3552; Fax: 907-772-3580
Email: changing@mitkof.net
Web site: http://www.mitkof.net/~changing
Available services: Outpatient Care, Aftercare, Prevention, and Outreach

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PILOT POINT
City of Pilot Point
Box 430
Pilot Point, AK, 99649
Phone: (907)-797-2206; Fax: (907)-797-2211
Available Services: Prevention

Appendix C Continued– C21

SAND POINT
Eastern Aleutian Tribes, Inc.
P.O. Box 527
Sand Point, AK, 99661
Phone: 907-383-6074; Fax: 907-383-6078; Email: rong@gci.net
Available Services: Outpatient Care, Aftercare

SELAWIK
Selawik
Selawik, AK
Phone: 907-484-2339; Fax: 907-484-2161
Available Services: Prevention

SELDOVIA
Seldovia Village Tribal Prevention Program
PO Box 197
Seldovia, AK, 99663
Phone: 907 234-7807; Fax: 907 234-7493; Email: skiap@xyz.net
Available Services: Outpatient Care, Aftercare, and Prevention

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SEWARD
Seaview Community Services
PO Box 1045
Seward, AK, 99664
Phone: 224-5257; Fax: 907 224-7081
Email: mstone@seward.net OR katz@seward.net ; Web: http://www.seward.net/~seaview/
Available services: Outpatient Care, Aftercare, and Prevention

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SITKA
SEARHC - Bill Brady Healing Center
222 Tongass Drive
Sitka, AK, 99835
Phone: 907 966-8360; Fax: 907 966-8494
Email: mickeys@searhc.org; Web site: http://www.searhc.org
Available services: Intermediate Care

SEARHC - Community Family Program
222 Tongass Drive
Sitka, AK, 99835
Phone: 907 966-8710; Fax: 907-966-2489; Email: ivag@searhc.org; Web: http://www.searhc.org
Available services: Intermediate Care, Outpatient Care, Aftercare, Prevention

Appendix C Continued– C22

SEARHC - Raven's Way
222 Tongass Drive, Pouch R
Sitka, AK, 99835
Phone: 907 966-8726; Fax: 907 966-8705
Email: anita.didrickson@searhc.org; Web: http://www.searhc.org
Available services: Intermediate Care, Aftercare (Adolescents)

SEARHC - Safe Harbor House (Deilee Hit)
222 Tongass Drive, Pouch R
Sitka, AK, 99835
Phone: 907 966-8641; Fax: 907 966-8705
Email: roberta_kitka@searhc.org; Web: http://www.searhc.org
Available services: Intermediate Care, Aftercare (Women)

Sitka Prevention & Treatment Services, Inc.
Aurora's Watch / Haven's House
P.O. Box 1034
Sitka, AK, 99835
Phone: (907)-747-3636/3500; Fax: (907)-747-3003
Email: strc@ptialaska.net
Available Services: Outpatient Care, Intermediate Care, Aftercare, Prevention, Outreach

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SOLDOTNA
Rational Insight Treatment Enterprises (R.I.T.E.) – Soldotna
145 Kasilof Street
Soldotna, AK, 99669
Phone: 907 260-7412; Fax: 907 260-7412; Email: rite@alaska.net
Available services: Outpatient, Aftercare

ST. GEORGE
St. George Traditional Council
P.O. Box 940
St. George, AK, 99591
Phone: (907)-859-2205; Fax: (907)-859-2242
Email: stgcouncil@aol.com
Available Services: Prevention

ST. PAUL
TDX Foundation
P.O. Box 88
St. Paul, AK, 99660
Phone: (907)-546-2312; Fax: (907)-546-2366; Email: mike@tdx.alaska.com

Appendix C Continued– C23

Pribilof Counseling Center
Aleutian/Pribilof Island Association, Inc.
PO Box 65
St. Paul, AK, 99660
Phone: 907 546-2342; Fax: 907 546-2343
Email: michelek@apiai.com
Available services: Outpatient Care, Aftercare

TALKEETNA
Sunshine Community Health Clinic
PO Box 787, Mile 4.4, Talkeetna Spur Rd.
Talkeetna, AK, 99676
Phone: 907-733-2273; Fax: 907-733-1735
Email: jstevens@sunshineclinic.org
Available services: Outpatient Care, Aftercare, and Prevention

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TANANA
Tanana Counseling Center - Tanana Tribal Council
PO Box 130
Tanana, AK, 99777
Phone: 907-366-7154; Fax: 907-366-7229
Available services: Outpatient Care, Aftercare

THORNE BAY
Communities Organized for Health Options (COHO)
PO Box 805
Craig, AK, 99921
Phone: 907-826-3662 OR 828-3381; Fax: 907-826-2917
Email: coho@aptalaska.net
Available services: Outpatient Care, Aftercare

TOGIAK
City of Togiak
P.O. Box 99
Togiak, AK, 99678
Phone: (907)-493-5820; Fax: (907)-493-5932
Email: cityoftogi@aol.com
Available Services: Prevention

Appendix C Continued– C24

TOK
City of Tok
PO Box 83
Tok, AK, 99780
Phone: 1-800-478-5185
Available Services: Prevention

Upper Tanana Program - Tanana Chiefs Conference, Inc. (TCC)
PO Box 83
Tok, AK, 99780-0083
Phone: 907 883-5185 OR 800-478-5185; Fax: 907 883-4332
Email: liz.webb@tananachiefs.org
Available services: Outpatient Care, Aftercare, and Outreach

UNALASKA
Aleutian/Pribilof Island Association, Inc.
Aleutians Counseling Center
PO Box 1130
Unalaska, AK, 99685
Phone: 907 581-2742; Fax: 907 581-2040
Email: jadirks@anthc.org
Available services: Outpatient Care, Aftercare

VALDEZ
Valdez City Schools
PO Box 389
Valdez, AK, 99686
Phone: 907-835-4552; Fax: 907-835-2041
Email: Sara_Irwin_goodreau@valdez.k12.ak.us
Available Services: Prevention

Valdez Counseling Center
PO Box 550
Valdez, AK, 99686
Phone: 907-835-2838; Fax: 907-835-5927
Email: nolannate@hotmail.com
Available services: Outpatient Care, Aftercare, and Outreach

Appendix C Continued– C25

WASILLA

Alaska Addiction Rehabilitation Service, Inc. - Nugen's Ranch
P.O. Box 871545
Wasilla, AK, 99687
Phone: 907-376-4534; Fax: 907-376-2348
Email: aars@mtaonline.net
Available services: Adult Residential, Emergency Services

Mat-Su Recovery Center,Inc.
291 E. Swanson Avenue
Wasilla, AK, 99654
Phone: 907-376-4000; Fax: 907-373-1135
Email: recovery@mtaonline.net
Available services: Outpatient Care, Prevention, and Aftercare

Rational Insight Treatment Enterprises (R.I.T.E.) - Wasilla
951 E. Bogard Road
Wasilla, AK, 99654
Phone: 907 373-7480; Fax: 907 373-7481
Email: rite@alaska.net
Available services: Outpatient, Aftercare

Starting Point – Wasilla (Private)
1075 Check Street, Suite 102
Wasilla, AK, 99654
Phone: 907 376-6116; Fax: 907 376-9193
Email: spa@pobox.alaska.net
Available services: Outpatient Care, Aftercare

WRANGELL

Avenues
406 Alaska Avenue
P.O. Box 1108
Wrangell, AK, 99929
Phone: 907-874-3338; Fax: 907- 874-3339
Email: avenues@aptalaska.net
Available services: Outpatient Care, Aftercare

Appendix C Continued– C26

Wrangell Police Department/School Liaison
P.O. Box 531
Wrangell, AK 99929
Phone: 907-874-3304; Fax: 907-874-2173
Email: wrgakpd@seapac.net
Available Services: Prevention

YUKUTAT
Yakutat Tlingit Tribe
P O Box 418
Yakutat, AK, 99689
Phone: 907-784-3375; Fax: 907-784-3664
Available Services: Prevention

APPENDIX D

The Twelve Steps of Alcoholics Anonymous (A.A.)

1. We admitted we were powerless over alcohol—that our lives had become unmanageable.

2. Came to believe that a Power greater than ourselves could restore us to sanity.

3. Made a decision to turn our will and our lives over to the care of God *as we understood Him* [sic].

4. Made a searching and fearless moral inventory of ourselves.

5. Admitted to God, to ourselves and to another human being the exact nature of our wrongs.

6. Were entirely ready to have God remove all these defects of character.

7. Humbly asked Him [sic] to remove our shortcomings.

8. Made a list of all persons we had harmed, and became willing to make amends to them all.

9. Made direct amends to such people wherever possible, except when to do so would injure them or others.

10. Continued to take personal inventory and when we were wrong promptly admitted it.

11. Sought through prayer and meditation to improve our conscious contact with God, as we understood Him [sic], praying only for knowledge of His [sic] will for us and the power to carry that out.

12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

(Alcoholics Anonymous World Services, Inc., 1976)

APPENDIX E

Twelve Steps and Twelve Principles: An Alternate Wording of the 12 Steps for Native Americans

Face the East—Finding the Creator

Step 1: Honesty
We admitted we were powerless over alcohol—that we had lost control of our lives.
Step 2: Hope
We came to believe that a Power greater than ourselves could help us regain control.
Step 3: Faith
We made a decision to ask for help from a Higher Power and others who understood.

Face the South—Finding Ourselves

Step 4: Courage
We stopped and thought about our strengths and our weaknesses and thought about ourselves.
Step 5: Integrity
We admitted to the Great Spirit, to ourselves, and to another person the things we thought were wrong about ourselves.
Step 6: Willingness
We are ready, with the help of the Great Spirit, to change.

Face the West—Finding our Relatives

Step 7: Humility
We humbly ask a Higher Power and our friends to help us to change.
Step 8: Forgiveness
We made a list of people who were hurt by our drinking and want to make up for these hurts.
Step 9: Justice
We are making up to those people whenever we can, except when to do so would hurt them more.

Face the North—Finding the Elder's Wisdom

Step 10: Perseverance
We continue to think about our strengths and weaknesses and when we are wrong we say so.
Step 11: Spiritual Awareness
We pray and think about ourselves, praying only for the strength to do what is right.
Step 12: Service
We try to help other alcoholics and to practice these principles in everything we do.

(White Bison, Inc., 2002, pp. 50-51)

APPENDIX F

Seven Philosophies for Native Americans

1. *Women*—The first of our natural values concerns our *women.*
   One of our great Nations, the Cheyenne People say it this way. "*A nation is not defeated until the hearts of its women are on the ground.*" . . . Violence against our women is not traditional. Sovereign women strengthen our sovereign nations. The woman has been given by natural laws the ability to reproduce life. The most sacred of all things is life. Therefore we should treat women with dignity and respect. Never was it our way to harm women mentally, emotionally, physically, or spiritually. Indian men were never abusers. We always treated our women with respect and understanding. A woman's cycle of life is the baby, girl, woman, and grandmother. Both men and women must respect this natural cycle because it is the basis for all life. We must also recognize and respect the female principle wherever we find it. . . .
2. *Children*—The second principle that governs us as Native people is our *children.*
   As an eagle prepares the young to leave the nest with all the skills and knowledge it needs to participate in life, in the same manner so will I guide those younger than myself. I will use the culture to prepare them for life. The most important thing I can give to children is my time. . . . We are caretakers of the children for the Creator. They are His [sic] children, not ours. . . .
3. *Family*—The next principle that governs us as Native people is the *family.*
   . . . the children's behavior is a mirror of the parent's behavior. . . I realize the importance of each Native man and woman to be responsible to the family in order to fulfill the need to build a strong and balanced family. By doing this I will break the cycle of hurt that affects our families today, and ensure the positive mental health of the children, even the children yet to be born. . . .
4. *Community*—The fourth principle that guides us as Native people is the community.
   . . . the most important is a sense of belonging—that is, belonging "to the people" and having a place to go. . . . In the community, *the honor of one is the honor of all, and the pain of one is the pain of all.* . . .
5. *Earth*—The *Earth* and the natural environment is the fifth principle of great importance to Indian People.
   Our Mother Earth is the source of all life, whether it be the plants, the two-legged, four-legged,, winged ones or human beings. The Mother Earth is the greatest Teacher, if we listen, observe, and respect her. When we live in harmony with the Mother Earth, she will recycle the things we consume and make them available to our children and to their children. . . .
6. *Creator*—Relationship with the Creator is the sixth principle that is a focus of Indian life.
   As Indian people, our tribes or Nations have hundreds of different words in our own languages signifying what we mean when we say Creator. I realize we make no gains without the Great Spirit being in our lives. Neither I, nor anything we do, will work without our Creator. Being Indian and being spiritual has the same meaning. Spirituality is our gift from the Great One. This day, I vow to walk the Red Road. . . .
7. *Myself*—The relationship with *myself* is the seventh principle that is important to us as Indian people. It is one that makes possible all that is good in life.
   First of all, we must have a loving and good relationship with ourselves if we are to walk the Red Road in a good way. We must care for our bodies by having good eating habits and having physical exercise in our daily lives. We must be careful not to live in a stressful manner on a long-time basis or we will fall into poor health—physically, emotionally, mentally, or spiritually. We must welcome relaxation into our lives day-by-day. I will think about what kind of person I want to be when I am an Elder. I will start developing myself now to be this person. . . . .

Note: This is an excerpt only—refer to the source for complete ideas about the seven philosophies.
(White Bison Inc., 2002, pp. A2- A9)